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Pulling the Drawstrings

Every good knitter has a bag into which she puts the odds and ends of yarn she has left over. Sometimes it will be a fair-sized ball, sometimes only a short strand. Periodically, she has a house-cleaning of this bag of left-overs and knits up the wool into more useful articles — coat-hanger covers, tea-cosies, afghan squares, babies' bootees, even darning holes in sweaters or socks — none of it is wasted. When the oddments are all sorted out, the bag is put away to become a store-room for further treasures.

Coming to the end of this year 1945, let us go through our work-bag. There are many colours left there from which we may make a pattern. Lord Byron once said, "The best prophet of the future is the past". What colours have we from which to weave our future?

First, there are the long, bright strands labelled V-E Day and V-J Day. What gloriously warm, rich hues those days were! The war was over in Europe and, in an amazingly short time thereafter, the war in the far eastern theatre came to an end. Golden threads a-plenty, as from far and near absent relatives and friends flocked homeward. There are sombre colours here, too, which reach across to grave-markers in many foreign lands. Some of the shades are dull just now, which next year may be brighter as the sick, the wounded, the prisoners-of-war are restored to the fullest possible measure of health. Bright threads, glad threads of victory!

Many more shining colours are over in this corner of our bag. These are all the hundreds of new friends the *Journal* has made in the past year. Every section of the Dominion has contributed strands to this ball. Student nurses, graduates, retired nurses, married nurses — a mighty assembly of friends to whom *The Canadian Nurse* is a welcome helper each month. The kindness and forebearance when delivery has been late has added an especial gleam to

these colours. These new colours blend well with the larger pattern of our thousands of old tried and true friends. May there be a host of new strands added to our work-basket next year!

A very large measure of the success of this past twelve months has been due to the multi-coloured mosaic woven by our contributors. Already, a very interesting pattern is taking shape for the months to come. In one section of the total colour scheme, the material has been a bit skimpy recently, leaving some unwanted gaps. "News Notes", which tells the more intimate story of nursing activity all over Canada, has not had threads from many of the provinces. Perhaps when the 1946 package unfolds, these pieces will be found more plentifully scattered.

There are so many other colours in our work-bag—the vibrant hues of music, the comfortable friendliness of books —shades and tints to numerous to mention. Christmas itself with its festive reds and greens is upon us. Let us pull the draw-strings on 1945 and wish to all those who have blended their colours with ours a very happy Christmas, quite the gayest and most joyful in many a year. For the New Year, the editor and staff of the *Journal* wish all of our readers success, great happiness, and a renewal of your subscription!

—M.E.K.

Competition Winners

We have much pleasure in announcing the names of the winners in the recent competition sponsored by *The Canadian Nurse*. The four winning papers will be published next year starting with the February issue. To each of these winners we offer our hearty congratulations and to all the contestants our appreciation of your response. It is hoped that a larger number will watch for the next competition, the topic for which will be announced early in the New Year.

The winning entries were written by: First place, Miss Grace Giles, Saskatoon, Sask.; second place, Miss Helen Saunders, Victoria, B.C.; third place, Mrs. Eileen Mayo, Toronto, Ont.; honourable mention, Miss Elizabeth Tweedie, Westmount, P.Q.

Preview

While there have been periodic articles dealing with various aspects of tuberculosis affiliation, etc., in recent issues, next month we propose to devote a considerable part of the *Journal* to this topic. Heading the list will be a very excellent and informative discussion on operative treatment of the disease through thoracoplasty. Dr. G. H. Hames describes the procedure in detail. Preoperative and post-operative nursing care will be outlined by Elsie Towers and Helene Kirkpatrick. What it feels like to be the patient is humorously portrayed by B. M. Evjen. A description of fluorographic surveys and the programs for the prevention of tuberculosis in Saskatchewan comes from the able pen of Grace Giles. Finally, a discussion on the scope and challenge of tuberculosis nursing written by Esther Paulson will round out this interesting and vital series.

Too Late and Too Little

LAWRENCE E. RANTA, M.D., D.P.H.

Usually with mixed feelings of pity and impatience, most members of nursing and kindred professions eventually cross words with conscientious objectors who voice disapproval of vaccination, chlorination, pasteurization, or some equally well-established health measure; and in the process of crystallizing a public health practice we often joust among ourselves. But our criticisms should not be the thrusts of a superior attitude, lest we, in turn, go misunderstood when we couch a lance from the back of our favourite "hobby-horse": for none of us ever escape completely from preconceptions and prejudices. However, if we hope to fly the banner of the "Modern Crusade" and realize our ambitions as health teachers in the community, we must ever make efforts to clarify our ideas regarding the best procedures in all branches of health preservation.

PERTUSSIS IMMUNIZATION

Disappointment in the older type of pertussis vaccine, made from an avirulent strain of *H. pertussis*, might be adequate reason to excuse us should we look skeptically upon later modifications. But we cannot spurn the proof offered by many excellent workers in Canada, United States, and elsewhere, that whooping cough can be prevented by inoculations with a vaccine prepared from Phase I, *H. pertussis*.

During the pioneer work with this newer vaccine attention was paid primarily to prevention of morbidity. The selection of older infants for immunization, though really governed by experimental necessity, has probably been responsible for the reluctance of many practitioners to administer pertussis vaccine until the infant approaches the first birthday. But, as Phase I pertussis vaccine has demonstrated its ability to prevent morbidity, we must consider how it can be used in the best interests of public health.

Each year of the first decade of life contributes about 10 per cent of the total cases of whooping cough, hence, inoculations of vaccine commenced towards the end of the first year of age could, ideally, influence 90 per cent of the prospective cases. But, although children under one year suffer only 10 per cent of cases, they contribute about 75 per cent of the total whooping cough fatalities. For example, in a typical year (1942), of 560 Canadians dying of whooping cough, 413 (73.7 per cent of the total) were less than a year old, and 499 (89.1 per cent) were under two years of age. In Chart I, the curve represents the percentage of the total number of fatalities from whooping cough occurring up to the age at which the curve cuts a vertical line. The steep upward sweep of the curve during the first year reveals how every month of infancy is paid for by a heavy toll of victims caused by our delay in stimulating resistance against *H. pertussis*. The obvious flattening of the curve after the second birthday indicates a marked lowering of the case fatality rate in the older age-groups. It is clear that, if establishment of immunity is delayed until the end of the first year in accord with widely prevalent practices, the best result we can hope for is a reduction of whooping cough mortality by approximately 25 per cent. This would still leave whooping cough at the top of the list of infanticidal communicable diseases. Consequently, our objective must be a postponement of the disease to any time after the second birthday. Moreover, the ar-

gument for early immunization is strengthened by the contention that pertussis immunity does not become solidly established until the third or fourth month after completion of the vaccine series.

Therefore, giving consideration to the innocuous nature of the immunizing agent, to the high case fatality rate during infancy, and to the delay in acquiring immunity after vaccination, pertussis immunization should be commenced as early as the second month after birth. The practicability of early immunization should be judged by the attending physician upon the infant's physical condition and development. If these are normal, or if the risk of exposure is great, there is no reason to postpone inoculation; for the argument that a young infant fails to develop immune bodies against *H. Pertussis* is not supported in the literature. But as the response to vaccination may not be as durable as that of an older infant, a reinforcing dose should be given on the first birthday.

It should be emphasized that pertussis immunization begun during the second month will not solve the problem of whooping cough fatalities: reference to Chart I will obviate further elaboration. But even though earlier immunization cannot recall the victims of our ignorance of better preventive practices, it can reduce the number of victims of our procrastination in the use of the tools at hand, until future developments either confirm the possibility of immunizing prospective mothers against whooping cough during the middle trimester of pregnancy, or provide us with more effective, rapidly acting, prophylactic measures.

The establishment of pertussis immunity may be secured by inoculations of pertussis vaccine alone, or in combination with diphtheria toxoid. The latter preparation has the real advantage of reducing the total number of immunizing injections.

The theoretical objection, that the ability of diphtheria toxoid to elicit antibodies may be neutralized by the passive-

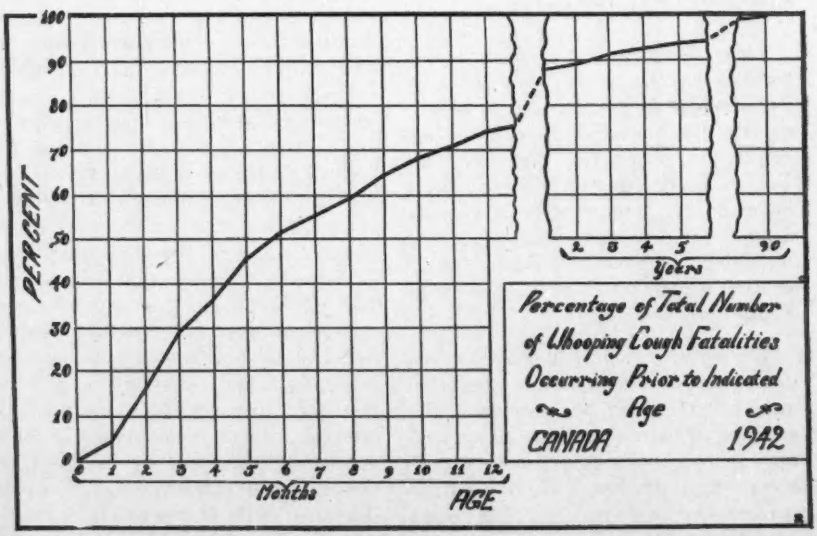

Chart I

ly transferred maternal antibodies possessed by many newly born, has not been proven by trial; on the contrary, there is much to nullify the objection. For some years after active immunization with diphtheria toxoid an individual possesses antibodies sufficient to confer immunity against the average infecting dose of *C. diphtheriae,* and to produce a negative Schick reaction. Yet even in these individuals a dose of diphtheria toxoid will, within certain reasonable limits, elevate their antibody titre to a higher level. In other words, despite the existence of circulating antibodies in appreciable quantities, the toxoid reinforces the antibody level.

One may also argue in favour of the combined immunizing agent by pointing out that many large-scale Schick-testing surveys of persons in the reproductive age showed that more than half often possessed insufficient antibodies to render them Schick-negative. Therefore, many thousands of Canadian infants are born without passive protection against diphtheria, and would profit from the diphtheria toxoid in the combined preparation.

Scarlet Fever Immunization

We do not condemn the use of pertussis vaccine on the grounds that it fails to justify itself as a "cure-all" of the whooping cough problem. Similarly, we should not label scarlet fever immunization as a useless procedure simply because it is unable to do all that we desire of it. But, oddly enough, some laboratory and public health workers thrill with an impulse to do battle when it is suggested that immunization against scarlet fever may have merits. However, scarlet fever immunization has many supporters among equally well-qualified and conscientious workers, and this support would imply that something can be said in its favour.

The objectors base their opposition on the claim that scarlet fever immunization prevents only the appearance of the rash when an individual becomes infected by an erythrotoxigenic strain of streptococcus and, as public health regulations do not ordinarily call for isolation of the rashless streptococcally infected, this procedure actually encourages the spread of streptococci. If erythrogenic toxin had a selective action solely upon the skin, the objectors could voice their opinions as though from an impregnable tower, conscious of their ability to withstand siege. But, can the mere act of naming a toxin limit its toxicity to the terms of its descriptive adjective? A misconception of this type has been responsible for placing too much emphasis upon the erythema-producing quality of erythrogenic toxin. The tendency has been to lose sight of the fact that the toxin does not act on the skin *per se.* The rash has wider significance. It indicates that toxin has been elaborated at the site of infection, usually in the throat, that it has spread from the site of elaboration, and that it has acted upon the capillaries throughout the body, *including* those in the skin.

The fact that rabbits can be quickly killed by intravenous injections of small quantities of concentrated and highly purified erythrogenic toxin is sufficient evidence that the toxin is not limited to its action upon the skin. Autopsy findings reveal nothing more startling than a similarity to fatal human cases of fulminating toxic scarlet fever, if one excludes the signs of local infection in the latter. Some animals show no pathological signs either in the gross specimens or on microscopic section, while others have undoubted signs of cardiac edema. The presence of albumin in the urine, which often occurs even in moderate human cases, indicates toxicity of the renal capillaries.

With our present knowledge none can say whether, in the average attacks of scarlet fever, the capillary injury in

organs well supplied with these vascular elements (heart, kidneys, liver, lungs and brain) might not be permanent in nature, and might not add a substantial sum to the total organic injury that occurs from various causes during a lifetime. Negation of the possibility of lasting damage gives the patient the dubious comfort of theoretical objections instead of a chance for protection.

Can objectors to scarlet fever immunization maintain a tenable position in the face of clinical experience with scarlet fever antitoxin therapy? With the fact before us that the therapeutic effect of the antitoxin is almost solely due to anti-erythrotoxigenicity, contrast the average, moderately toxic case of scarlet fever at the time of antitoxin administration with the patient's appearance 12 to 24 hours later. Coincident with the fading of the external manifestations of capillary poisoning, the patient is transformed from a person, sick, hot, and disinterested in his surroundings, to one markedly improved, comfortable, and alert. If one can, by the use of scarlet fever immunization, prevent the patient from receiving the systemic insult delivered by erythrogenic toxin, the patient will have been done a great service.

Whether the prevention of scarlet fever will do the patient's community a disservice is highly improbable. If one takes the general Canadian carrier rate of Group A *Streptococcus hemolyticus* as being 15 per cent (in some urban surveys it has been found much higher), and if one increases the rate at one time by the annual number of prospective cases of scarlet fever, it would not reach 16 per cent. How significant this rise would be is conjectural. But the evidence presented by closed communities, such as nurses-in-training, indicates that scarlet fever immunization does not increase the number of streptococcal infections.

However, even if scarlet fever toxin were to be accepted as universally as diphtheria toxoid, it would be necessary to recognize its limitations. Were every person to be rendered Dick-negative it would not assure the disappearance of scarlet fever, for some rare strains of the causative agent produce erythrogenic toxins unneutralized by antitoxins elicited by immunization or, for that matter, by natural infection with streptococci producing the commoner erythrogenic toxin. Furthermore, all persons inoculated with the recommended five doses of scarlet fever toxin do not develop sufficient antibodies to protect their capillaries completely from the effects of the commoner erythrogenic toxin. This situation is comparable to the occasional failure of diphtheria toxoid to induce an immunity against an infecting dose of *C. diphtheriae*, although failures occur more frequently with the former than with the latter.

Yet none of these objections or limitations should be used as indictments against scarlet fever immunization, for the whole problem revolves about a fundamental principle of preventive medicine: whether it is better to depend upon naturally acquired immunity, and run the risk of permanent injury to the patient, or whether we minimize the risk by using the best available tools. The choice appears self-evident.

Preview

By special permission, we are privileged to bring to the readers of *The Canadian Nurse* the very stimulating discussion on "The Professional Status of Nursing" by Genevieve Knight Bixler and Roy White Bixler which was first published in the September, 1945, issue of the *American Journal of Nursing*. Their careful analysis of how well nursing measures up to appropriate criteria is well worth careful study.

The Problem of the Paralyzed Bladder

S. A. MacDonald, M.D.

Paralysis of the bladder has always been and still remains a serious clinical condition. Any interference with urinary drainage whether from the kidneys, ureters or bladder is invariably fraught with dire consequences. These are due to the stasis of urine which inevitably results. Of the many sequelae which occur infection is one of the first to appear. It inevitably follows whenever prolonged obstruction occurs anywhere in the course of the urinary tract. Sooner or later it is followed by back pressure damage which occurs in one or both kidneys depending on the site of the obstruction. Calculi are also prone to form above the obstructed area. If the condition is unrelieved the kidney substance and function are destroyed. If the damage is bilateral death eventually occurs from urinary sepsis or uremia.

All of these effects are associated with bladder paralysis. The inability of the patient to empty the bladder means that there is always left within the organ a pool of unvoided urine. This static reservoir leads to all the critical complications listed above. In this respect such a patient resembles the elderly man with an enlarged prostate, who similarly is unable completely to empty his bladder, and carries a persistent residue. Many of these patients, whether paralytic or prostatic, when questioned will say that they pass a normal amount of urine each day. Some will even claim to pass too much; in proof of this they will relate their day and night frequency. A fairly typical history is that of Mrs. X:

A white woman, aged 52, admitted with the following complaints: (1) Day and night frequency of urination — six months; (2) passage of malodorous urine — one month; (3) hematuria — one week. Any previous urinary tract symtoms were denied. Fifteen years ago she received an uncompleted course of treatment for syphilis.

Examination revealed Argyll-Robertson pupils, absence of knee jerks and partial anesthesia of the legs below the knees. The bladder was distended to the umbilicus and completely insensitive.

A diagnosis of *tabes dorsalis* with bladder paralysis was made. The management of this condition and the control of the hematuria were the immediate problems. The patient was voiding thick, deeply red, foul-smelling, grossly infected urine. A urethral catheter was inserted and a constant bladder irrigation was begun. The bleeding rapidly ceased and the bladder urine quickly cleared. The bleeding had been caused by inflammatory ulceration of the bladder mucosa. The disagreeable odour had resulted from the infection of the bladder and the disintegration of blood clot within it. The diagnosis of neurogenic bladder was confirmed by cystoscopy, cystograms and cystometric studies.

In the hope that dietary deficiency with B avitaminosis might be responsible for the condition large doses of B-complex were administered but without effect. Parasympathetic nerve stimulants were also utilized but to no avail.

The patient had a completely flaccid, insensitive bladder which was incapable of contracting and producing normal urination. In such circumstances an ineffective type of urination can be produced by increasing the intra-abdominal pressure. This is effected by contraction of the abdominal and diaphragmatic muscles. An over-flow type of micturition occurs but complete emptying of the bladder does not take place, and residual urine gradually accumulates.

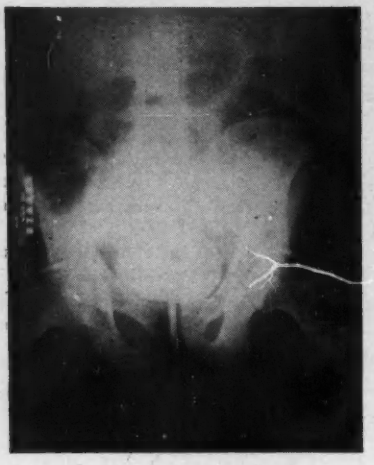

Fig. 1. Normal bladder filled with opaque solution (cystogram). Observe smooth regular outline and oval shape.

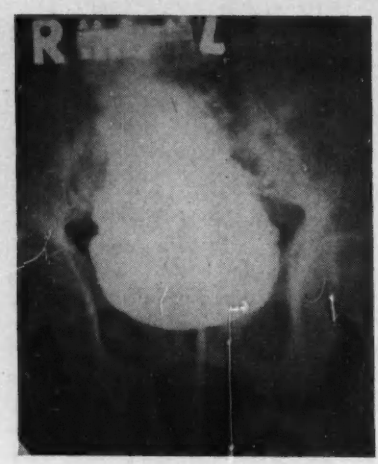

Fig. 2. Patient's cystogram. Observe irregular outline, large size tapered fundus.

In this case it amounted to 2000 cc. Corrective operative procedures sometimes can be employed. The three most commonly utilized are permanent supra-pubic cystostomy, trans-urethral resection of the bladder neck and presacral neurectomy.

Palliative treatment was decided upon at least temporarily for this patient. She was instructed in periodic attempted emptying of the bladder and was also shown how to perform manual expression. By these means, combined with daily bladder irrigation and emptying, and the administration of urinary antiseptics, her general condition immeasurably improved.

This patient had what is known as an atonic bladder. Three distinct types of bladder paralysis are now recognized. These are: (1) The atonic bladder; (2) the autonomous bladder; (3) the automatic or reflex bladder.

In the atonic group, the lesion present interferes with the normal sensory impulses and destroys the spinal reflex arc. The bladder is characterized by low intra-vesical pressure and complete absence of any waves of contraction. A large residue is always present and voiding is of the overflow type. The disability is usually permanent.

The autonomous bladder is the result of a lesion in the sacral portion of the spinal cord, the *cauda equina* or the pelvic nerves (anterior sacral roots). There is resulting interference with the normal motor innervation of the bladder. Normal bladder contractions do not occur but feeble inefficient contractions do take place. They probably represent an inherent capacity of the smooth muscle of the bladder wall to contract, or demonstrate reflex mural activity. The bladder has increased tone and decreased capacity. Voluntary control of urination is lost and the resulting incontinence is both active and passive.

The automatic bladder is produced by a lesion of the spinal cord above the sacral level. In these cases the sacral arc, or so called micturition reflex, is intact. This type of bladder is characterized by decreased capacity, increased tone and waves of reflex or automatic contraction. All voluntary control of micturition is lost and most vesical sensation is absent.

In the presence of permanent nerve

destruction the clinical management of all three groups is unsatisfactory. In the case of Mrs. X, no recovery of bladder function can be expected. Her excellent response to treatment largely reflects the nursing care she received. These patients are all confronted with prolonged illness; many of them face permanent disability with more or less chronic invalidism. Their nursing demands are many and not the least of these is the need for cheer and encouragement. If there is an associated paralysis of the extremities, as in many war casualties, the need for skilled nursing care is still greater. To maintain the patient's morale in such circumstances is a triumph of the art of nursing and, at the same time, to satisfy the patient's physical needs all the skill of the nursing craft is required.

Editor's Note: Under the caption "Using the Psychological Approach", Clara R. Aitkenhead has described the teaching opportunities which the case of Mrs. X afforded. How the nursing care resulted in improved morale in this patient is recorded on the Hospitals and Schools of Nursing Page in this issue.

The Care, Maintenance and Conservation of Hospital Equipment

W. J. COLEMAN

The long years of war when new instruments, materials, and equipment have been difficult to procure have put a severe strain on the supplies of these articles in use in the hospitals in Canada. This compilation of information will assist in keeping these things in as good repair as possible until replacements are available.

RUBBER GOODS

It is not necessary to dwell on the difficulties of procurement of the raw rubber at this time. Prominent authorities estimate that it will take at least two years after the Japanese are ousted from Singapore before there can be any quantity of manufactured natural rubber on the market. The British, American, and Canadian Governments set aside certain stocks for the restricted manufacture of some hospital items, gloves, special urological catheters, Penrose drains, etc., but these stocks are meagre and every effort must be made to conserve what is in use. Firms are forbidden to sell either natural rubber gloves or synthetics to any but hospital and doctor customers. Other items than those just mentioned are mostly made of synthetics — generally Neoprene, but in the case of present day sheeting it may be almost anything. The most important item in the rubber group is *gloves*. Most of you will be using when possible the pure latex, sometimes just called "white" gloves, although all white gloves are not necessarily latex. These, if properly handled, are the most durable of all rubber gloves, but they have some characteristics which if not taken into account lead to very quick deterioration. First, if allowed to properly re-vulcanize after sterilization they will last a good deal longer than the cheaper varieties. The revulcanizing is not something for

you to worry about — the rubber will do it by itself, if it is properly dried after coming from the sterilizer and allowed to rest for at leasty twenty-four hours, forty-eight hours if it can be managed. Second, do not test gloves for holes by blowing up to any marked degree when wet. Let them dry after the initial washing and rinsing before testing. Latex rubber is weakest when wet. Consequently, the "ballooning" of fingers in testing results in many "pops" unless gloves are dry. Keep all rubber gloves from sunlight and when drying latex particularly, do not hang in front of an open window or on a window sill. The passage of cool air over wet gloves can and does cause the formation of small holes, like pin holes, particularly just at the base of the fingers.

Be careful in your cleaning. Soap and plenty of good warm water are indicated. If you wish, mild blood solvents can be used with good results. Do *not* use alcohol, ether or other spirits as these will also dissolve the rubber. Blood solvent will not harm rubber and will dissolve normal human oils such as a glove collects in an operation. Water will take off any of the better known "water soluble" lubricating jellies. Try to have your doctors use as little liquid petrolatum or vaseline as possible with gloved hands. All grease causes deterioration of rubber. One word about sterilizing. Go to quite a bit of trouble to keep your gloves away from hot metal. I suggest that when you place your glove envelopes in the autoclave, you place under them a towel or folded sheet to keep them well away from the metal tray or the sides of the sterilizer.

The next problem concerns *tubing*. Most of what is in use now is stiffer than the old stock. This means that it is built up with a greater percentage of filler — foreign material — or it may be synthetic. It is also more brittle. Rubber tubing, even when the best is procurable, should always be stored in a loose coil — never folded. With the new material this coiling should be done with even more care. Coil also when sterilizing, either around large wooden spools or, as some hospitals do, have flat boards fitted with a number of pegs in a circle so that the tubing can be coiled around them. This also helps to keep the tubing from touching the walls of the autoclave. Also, clean your tubing carefully, inside and out. The Red Cross Blood Donor Clinics used blood solvent routinely for this purpose.

Rubber catheters. It has always been advised that catheters should be stored flat and straight in special boxes or tubes or even in the bottom of a long drawer. Those available at the present time are practically all synthetic, as good or better than pure rubber, but more brittle. Keeping them flat is even more important than heretofore. These new synthetics are not as easily affected by grease as pure rubber but we would still advise the use of a good surgical lubricant rather than liquid petrolatum for lubrication. It is a much better lubricant and more easily removed when cleaning.

Rubber sheeting as available right now is all synthetic and of different kinds. It is stiff, the fabric separates easily. Never fold rubber sheeting. Always store it rolled around a stick or cardboard the full width of the sheeting. That old advice is very important with this new stiff sheeting. When you receive rubber supplies in your hospital try to store them as you would adhesive plaster, in a cool dry place. Too often store rooms in hospitals are located down near the furnace with overhead steam pipes making the store room excessively warm. Just a word about one other rubber item. You are familiar with the latex rubber operating table, stretcher and maternity table pads, commonly called *Dunlopillo Pads*. These pads need very little care and will last for years providing one precaution is taken. They are fitted with a tight envelope of rubber sheeting. This is on there for two reasons — one, of course, to keep the por-

ous pad from becoming soaked with blood or other fluid; the other is to protect the pad itself from light and air. When you find this rubber sheeting envelope badly deteriorated or torn, please replace it promptly. Otherwise your good Dunlopillo Pad will turn into a sort of gray dust in a comparatively short time.

Surgical Instruments

Scissors, forceps, retractors, etc., are somewhat of a problem these days — difficult to procure, expensive and not always of high quality. Also, there is a decided trend in recent years for hospitals to buy and supply them rather than for individual doctors to have their own. With all these things in mind it becomes increasingly important to conserve what we have. It is recommended that hard scrubbing to remove tissue and blood be curtailed to the minimum conducive to aseptic conditions. Try not to leave instruments too long with blood dried on them. Bland blood solvents can be used in a good many cases to obviate scrubbing at all. Hard scrubbing tends to wear locks, lift plating and dull cutting edges.

Locks of artery forceps and needle drivers require special attention. Box lock instruments have a tendency to tighten and consequently stiffen if the trouble is not corrected. When this occurs a doctor or nurse, when under the nervous tension associated with the performance of a difficult operation, may impatiently attempt to force the instrument and in doing so spring or bend it permanently out of line. Locks can be protected to some extent by thorough cleansing and proper lubrication with some good light-weight lubricating oil — and once again not mineral oil. Several hospitals use "three-in-one" oil. This is good and there are others that are just as satisfactory. If a lock does develop a condition of tightness or binding it should be immersed in a medium strong solution of green soap and gently opened and closed until the corrosion is worked out. Then immerse it in oil and use the same process of gently opening and closing it until it works smoothly.

Screw lock instruments are also subject to lock trouble but instead of tightening they tend to loosen. Proper cleaning and oiling is also indicated with them, but when they get loose you would be well advised to have them repaired without delay as a loose lock will mean poor occlusion of both ratchets and teeth and consequent excessive wear.

To sum up, clean all instruments thoroughly and with as little abrasion as possible, oil carefully and keep all in good repair. The old adage "a stitch in time" has never gone out of date.

Some months ago a scalpel blade sharpening service was offered to the hospitals and medical men of Canada for all makes of detachable blades. The machinery for this processing was very expensive but apparently very efficient. The firm that undertook to supply the service sent one of their best men down to the United States to find out how to perform the operation and also how to set up and service the equipment needed. Most of the large hospitals in Canada, together with the leading surgeons, have already availed themselves of the service with apparently entire satisfaction. The cost of sharpening and reconditioning these blades is something less than one half of the original cost of possibly the best-known detachable blade. Surely this is real conservation of metal and labour.

Stainless Steel Ware

Included under this heading are bed pans, kidney basins, sponge bowls, etc. You probably have in use in your institutions a certain quantity of it, and are

doubtless planning to equip more completely when a further supply is available. Stainless steel is undoubtedly the most durable type of all utensil material but there are some misconceptions about its complete indestructability. It is subject to dissolution and consequent pitting when exposed to certain chemicals. One of the largest manufacturers warns against solutions of Zonite, Iodine, Dakin's Solutions, Hygeol, Mercuric Chloride, Bichloride of Mercury, Hychlorite, Corrosive Sublimate and Sodium or Calcium Hypochlorite, advising never to leave them in contact with stainless steel for more than six hours. If there is danger of damage at six hours there is undoubtedly a lesser danger for a lesser period. Also as mercuric compounds seem to be the chief offenders, we should add to the list of "be careful" items two well-known trade name products — Abbott's Metaphen Compounds and Lilly's Merthiolate Compounds. When it is necessary to use any of these solutions we suggest that you use them for as short a time as possible and then wash and dry thoroughly after each exposure. Stainless steel is a solid metal alloy and if kept well scoured will keep its bright surface and last for years.

Hypodermic Syringes and Needles

One of the chief causes of syringe breakdown is sticking. Immediate and thorough cleaning after use can obviate this to a great extent. Good solvents are again of value in this process. Syringes are in short supply. By all means treat what syringes you have with added respect for the next few months.

The hypodermic needle supply situation is much the same as syringes — short, very! A good many sizes that were formerly made and used are no longer available, but there are, in most cases, substitute sizes which are fairly satisfactory. Because of this during the past several years there has naturally been consideration given to the advisability of re-sharpening used needles. Two methods are available. One by the use of an electric motor operating a high-speed emery wheel. In the hands of an experienced operator this results in hollow grinding comparable with the initial factory precision job. The equipment is quite expensive and hardly feasible for the small institutions. The other method is by hand on a small soapstone. It is not nearly as successful as the emery wheel process and the time involved makes the cost almost prohibitive. However, this method can in some cases remove "hooks" on needles that would otherwise have to be discarded. It is important to learn the proper angle at which to hold the needle to the stone.

Equipment and Utility Services

Possibly the most expensive and important single unit in the hospital is *sterilizing apparatus*. As manufactured in modern times it is comparatively trouble free and self-operating. However, that does not mean that it should be expected to go on year after year giving good service without some care. All machinery needs periodic checking up and adjustment. There are only a very few points on a sterilizer battery or on a bed pan sterilizer that need oiling, but all hinges should be lubricated occasionally to effect easy operation and to eliminate wear. On the initial installation of equipment you have every right to expect assistance and supervision from your supplier, and possibly for six months thereafter. However, it is hardly fair to expect such supplier to keep on giving you service for years. Your own engineer should undertake to keep all valves tightened, replace valve seats when necessary and clean steam traps. This last chore incidentally is something, on an autoclave particularly, that should be done

routinely, possibly every three months, as most cases of poor dressing sterilization are definitely attributable to a steam trap that is not working freely. In one hospital with which I am familiar there is a regular contract with a local plumber for a complete check-up of all plumbing every three months, and this also includes all valves, steam traps, fittings, etc., on their sterilizers. That same hospital, incidentally, has a contract with a local electrician for a monthly check-up on all electrical service, including such things as operating room lights, quartz lamps, diathermy machines, electric food conveyors and so on. They believe that they save money by so doing.

One more thing about sterilizers. You all know the appearance of the pre-war instruments which were beautifully plated either with nickel or chrome. A good many executives have asked what to use in cleaning them. I can only pass on to you the advice of the manufacturers and this goes for any plated surface. They all advise "Bon Ami" and not substitutes. Brightly nickled or chromed sterilizing apparatus has not been available for some time, but if you have in your institutions some equipment of wartime manufacture it is considered just as durable as pre-war, and frequent polishing will very likely in time improve its appearance. Most finishes supplied at present are either "Matte" finish stainless steel or Everdur metal. Bright plating will, of course, eventually come back.

Keep the burners of *quartz lamps* clean. Dust or finger marks left on it will imbed in the quartz and stop emission of rays. Use a dust cover when not in use. See that electrical contacts are kept clean. Do not move the apparatus when lighted.

For *diathermy apparatus* or short-wave equipment use a dust cover. Be sure that electrode connections are kept clean. Periodically the cover should be removed from the back, or top as it may be, and the interior cleaned with a vacuum cleaner, being sure not to bend or displace contacts. An accumulation of dust can cause a short circuit and fire.

On *basal metabolism* apparatus once again use a dust cover. Remove and dry valves periodically. After every three or four tests drop the patient-ends of the breathing tubes to the floor to allow condensation water to drain out.

There are several different kinds of *baby incubators and resuscitators* and with different characteristics. Generally it is advisable to have your incubator drained of water — if it uses it — when not in use. If you use a Heidbrink resuscitator, a dust cover is again of advantage to protect the flowmeters.

Operating tables. The ordinary low priced table needs very little care although a little oil or grease on all moving parts is once again very useful. Hydraulic tables on the other hand do need periodic attention. Most of them, for the first two or three years after they are put to use, need only to be tightened and to have the odd oil-hole filled. After that, however, there are leather washers or gaskets to be replaced, the oil in the pump should either be replaced or removed and filtered then returnd to its cylinder in the base of the table. There are adequate instruction manuals for all these procedures and if you haven't one on file covering the tables in your hospital I would suggest that you procure one so that when it is needed your engineer can undertake an overhaul job without delay. I wouldn't say that overhauling one of these big hydraulic (or oil-o-matic as they are sometimes called) machines is an easy job, but it doesn't need an expert. Patience, a strong back and a little common sense are all that is needed.

Gas anesthesia equipment is to some extent an item apart, in that the doctor using it is generally a trained anesthetist and has his own ideas about care and maintenance. Consequently, I will not touch on the subject except to tell you that there will undoubtedly be a greatly increased number of them in use from now on and that possibilities of getting expert service for them will be improved.

From One Post-War Period to Another in Canada and India

EDITH BUCHANAN

Then the war cut across the face of progress in hospitals and nursing, not in 1939 nor for the first year or two, but increasingly and progressively in the next years. Finally it underlined so clearly the vast need for nursing in India, that it forced attention and brought far more study of the problem. A very few facts and figures may help to show the magnitude of the health problems and the need for nurses in India.

In India the death rate is twice that of Canada and the maternal and infant mortality rates are high.[1] The average expectation of life at birth is twenty-seven years (as compared with sixty in Canada).[2] Preventable causes, including communicable diseases such as malaria, dysentery and diarrhoea, cholera, small-pox, typhoid, plague, etc., account for well over three-quarters of the deaths.[3] One half of the deaths are in children under ten years of age due to poor nutrition.[4] Deficiency and nutritional disorders are marked and add to the common and severe anaemia found among women and children.

India is a tropical country with some of the greatest variations in temperature and in rainfall in the world.[5] Tropical diseases are, therefore, found. Student nurses, for example, have to study a whole section in medical nursing which we in Canada have not had to consider at all. Further, the health of a community, as Dr. Grant points out, depends upon social and economic conditions, on education, and upon the public health services.

First then, something about social conditions. In India, not counting the native states, there are over 247 persons per square mile as compared with 5.74 in Canada (excluding the N.W.T.) The increase in population has been 15 per cent in ten years, or over four times the total population of Canada.[6] More than three-quarters of the population make their living by agriculture. Certain social customs prevail which spread disease, such as bathing in and drinking the same water, using the banks of streams, rivers and roads for defaecation, and floating imperfectly cremated bodies down the rivers. Seclusion and early marriage of women, together with hard physical toil among working women, produce a high female mortality between ten and twenty years. Secondly, the average annual income is Rs. 65 (about $15).[7] And thirdly, the literacy figure is only about 12 per cent.[8] This is complicated by the number of dialects which the census quotes as 222. About a dozen of these are distinct and separate languages.[9] Finally, India has some 42,000 doctors and some 7000 nurses [10] (one nurse to 56,000 population). In most western countries there are about two nurses to a doctor. There are almost no public health nurses.

The war has brought an increased study of figures such as these. It cut across the face of nursing progress, as mentioned above, and hit the hospitals badly. Many of the more highly qualified nurses joined the army. Indian nurses, who had been going abroad for special advanced training, were unable to go. No more persons with training for positions of responsibility were available from Europe or America. A large proportion of the staff nurses, not a great number in all, went to army hospitals. Schools of nursing and nurses' homes suffered badly. The quality and amount of teaching and the quality of the residential life deteriorated.

The many opportunities for joining auxiliary nursing services and service corps, such as the W.A.C.I., at better salary than that of qualified staff nurses and sisters, all tended to reduce the number of applications to schools of nursing.

Some leaders, however, had been alive to these trends and worked continuously for nursing. Some sister tutors (instructors) who applied to join the army, were asked to stay at their posts, and sister tutors in the army were given special teaching positions to give further training to those of the auxiliary personnel who wanted to qualify as nurses. Finally the appalling lack of nurses for army and civil population alike began to come home to all and sundry. The Trained Nurses' Association of India (T.N.A.I.) had been hammering away, just as the C.N.A. has done for years, at getting improved nursing education as basic for getting more and better nurses. For some years a School for Graduate Nurses had been planned, and some funds raised towards an endowment. A curriculum had been drafted in readiness. Finally in April, 1943, the army need for short wartime courses in administration made it possible to open such a school, half under military and half under civilian auspices. The Department of Education, Health and Lands of the Government of India sponsored the preparation of instructors of nurses for civil hospitals, and the army sponsored short three-month courses in administration for Indian military matrons and assistant matrons. Lady Linlithgow formally opened the School of Nursing Administration in part of the big Health School in Delhi. Sir Jogendra Singh, the Minister of Education, Health and Lands, participated, as also did the directors general of Civil and Army Medical Services in India.

We started with small groups in the school — six sister tutor students (instructors) and six army students in administration. (These last changed every three months). Just two of us formed the internal or permanent staff — Miss M. Craig of Johns Hopkins, with her Master's Degree from Columbia, as director, and myself as sister tutor and assistant. We were able to draw on highly qualified external lecturers from Delhi University with its various colleges, from the Lady Hardinge Medical College, from the Army Nursing[11] and Army Nutrition Headquarters, from the Lady Reading Health School and Central Government Maternity and Child Welfare Bureau.[12] The aim in the instructor's course has been to make the work taken of university standard. The city hospital schools of nursing and the health school and services provided observation and practice fields. Practice teaching in two languages was done in five different institutions. Two civilian and two military hospitals (the Indian and British Military) provided practice fields for the courses in administration and the American Military Hospital was visited.

Our army students had been in hospital behind the front line, some had been torpedoed, some wounded. All had had to cope with stupendous problems of supply and organization and an utter lack of trained personnel. It was a privilege and a humbling experience to work with them.

The student teacher group was com-

Lady Linlithgow talking to the children in the Health Centre.

The first students at the School of Nursing Administration when it opened in April, 1943, with Miss Buchanan.

posed of representatives sent by the different provinces of India. During the first year some were Indian, some Anglo-Indian and some European. The group this last year has numbered fifteen, including one qualified male nurse, and is, almost entirely, an Indian group. Again the problems that these young instructors are having to cope with are exceedingly heavy. Much is needed and expected of them, and not nearly enough help and wise guidance is available as yet! All the traditions are still to be built. But they are the beginning of a foundation built in India itself for the future. Trained in India, knowing the language and the problems, and teaching Indian nurses you may imagine with what high hope we see them go out all over India. One of these days there will be a Florence Nightingale, a Miss Nutting or a Flora Madeline Shaw among them.

Just as the last post-war period saw the opening of all our Canadian University Graduate Schools of Nursing, with the great development of teacher-training and the wide introduction of teachers into schools of nursing; of public health training; just as it saw the development of combined university and hospital schools, and then the development in the United States and Canada of the complete independent school of nursing in the university, giving and controlling the complete and all-round basic training course in nursing — so this post-war period is going to be of immense importance to India, to Canada and the United States and the whole world. If we are ready for it and know what we want, we can guide and crystallize public interest in nursing and use the post-war momentum to accomplish our dearest hopes for the future of nursing.

In India then, as elsewhere, we are commencing a great period in nursing. We are aiming at a million nurses in thirty years (to give one nurse per five hundred population). The Trained Nurses' Association of India is appealing to every Mission Board to help in more and better training of nurses, improvement of schools of nursing and nurses' homes, development of public health work of every kind. We are asking every nurse who goes to India from a Western country, however she goes, or under whatever auspices, to prepare

herself with the best that her country has to give. She must give far more than a part or mere portion of what she got. She must read and study and learn so that she can pass on *more* than she received. Those of us who graduated a few years ago have the advances and developments in health and preventive work, of recent years, to master. Everyday nursing is progressing. No Western nurse in India can escape heavy responsibility for improving nursing education, for broadening nursing to include its rightful health and preventive aspects, and for working towards a sound scientific and professional preparation of nurses in India.

Further, there are now a good many Canadian, American and British nurses who know India, perhaps from a childhood spent there, or from army or other experience. This is a group who have a special contribution to make if they will prepare especially as teachers and public health workers and come to the India they loved as children, to build up nursing in the post-war period. Some definite affiliation such as a mission board, an international health service, or family or connection in India is very necessary. Some positions just have to be worked into. Remember that you may spend four or five years paying back a debt due to sickness liabilities in your first year out if you do not have some definite arrangement or affiliation. It takes a year or two to adjust and build up immunity and a healthy routine. However, since India is very dear to many of us, and since we have the knowledge of the past and an ear for the language, we have an understanding and affection which helps us to see promise and to see clear and possible lines for advance.

Right now there is very great hope of Independent Collegiate Schools of Nursing being started in India for the basic and all-round training of public health nurses. The T.N.A.I. has worked for one in Delhi for some years and hopes that it may be established with the post-graduate school very soon. Already also the missions co-operating in the National Christian Council in India are working to establish a school affiliated with Madras University at Vellore.[12] Various Indian universities seem to be interested in setting up collegiate schools. The difficulty is to get the matter so soundly based that both university and nursing may benefit and prove an enrichment each to the other.

A thoroughly sound way of being sure that the teaching of the subject of nursing is improved is to get complete educational control by having the school financially independent of the hospital, by putting expert nurse educationalists in charge, and by using hospital and public health fields for practice, that is, for the practice necessary for learning, and not all the repetitive work necessary for servicing as such. This means that money is needed — an endowment, or state, or university support — for the getting of which the post-war period provides a great new opportunity.

An equally sound and thorough way of being sure that we, as nurses, really do get a full university education, with nothing "ersatz" about it, is to fulfill the complete university requirements for a Bachelor's Degree in Pass Arts (quite over and above any purely nursing or clinical subjects), taking liberal subjects and choosing biological and social sciences related to nursing. For example, this might mean entering the university with senior matriculation (thirteen years of schooling) and then taking fifteen academic courses ordinarily spread over three years of eight months each (twenty-four in all). In addition to this, however, the honour subject of nursing, with all its related clinical subjects, would be added and integrated very carefully with the biological and social sciences, and then the whole would be spread out to cover a period of four full years (forty-four months when holidays have been subtracted). This means that in the four-year period a clear twenty

months are used for nursing subjects with co-ordinated practice. In addition, nursing as the honour subject, or specialty, is taken closely co-ordinated with other subjects throughout the whole four years as any honour subject would be, no more and no less.

Another method which involves the same total years of schooling in the end is to enter the university with junior matriculation (twelve years of schooling), take two years of pre-nursing work at the university, including liberal subjects and certain required sciences such as biology and chemistry. The student then enters the nursing school in the university. There she takes further biological and social sciences basic to nursing, and nursing itself as the major subject with all its clinical branches in a course of thirty months. This is followed by a "staff student" or senior cadet period of six months.[14]

And so after eight years in India it has been wonderful to be home in Canada this year. I have been studying the Independent School of Nursing (under a Rockefeller Fellowship granted at the request of the Government of India). I hope to be able to put it all to the most thorough use, by helping in the building up of an Independent School of Nursing in India.

No one who has studied the Independent School seriously can fail to realize the great educational advantages — first, to nursing and nursing education, giving educational freedom and an intellectual approach in the teaching of the actual subject of nursing itself; second, to nurses as all-round and socially minded individuals; and third, to the community, making possible a broader and a more highly specialized contribution to its welfare. As nurses, we need an intellectual and scientific preparation to enable us to contribute that share in the planning of the post-war period for which we are justly fitted by broad social experience. Just as Canada has played such a real part in the development of the modern independent school so now she needs to lead the way in perfecting it in various different forms, and in using it far more widely. Canada needs a great number of different types of Independent Schools of Nursing — endowed hospital schools, state-supported and university schools. In short, no nurse can afford to be blind to the clear-cut educational advantages that other professions — having had independent professional schools for many years—have so long enjoyed. No nurse can afford to neglect this post-war period to try to make up the deficiency.

It is a proud matter for us, who travel away from home, to hear of Canadian nurses in the forefront of modern developments. We will watch with special eagerness the accomplishments of Canada in this great new era before us.

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10. Nursing Journal of India, May, 1944, p. 157.

11. Mrs. Wilkinson, now in charge of the Queen Alexandra Imperial Military Nursing Service, was then in charge of the Indian Military Nursing Service, and did a great deal to help in starting the School of Nursing Administration.

12. Dr. Jean Orkney, officer of Maternity and Child Welfare, who helped us very greatly, visited Canada and the United States on a Rockefeller Fellowship only a few years ago and will be remembered by many Canadians.

13. Nursing Journal of India, Feb. 1945.

14. Both students and staff at the School of Nursing, Vanderbilt University, are enthusiastic about the senior cadet period.

Central Supply Room

DOROTHY L. WARD

With the increasing shortage of nurses and in an earnest desire to maintain adequate nursing service a Central Supply Room was organized in the Homoeopathic Hospital of Montreal, in November, 1942. Such a department conserves both time and material and ensures better standards of performance. It was felt also that this department would relieve the ward nurses of many mechanical duties thus allowing more time for bedside nursing. The head nurse, too, is relieved of the responsibility of care of equipment, thus givin her more time for ward supervision and the many added duties which have become her lot in present times.

In the spring of 1942, a survey was made and it was decided that a ward dressing room and a service room, situated on the top floor of the hospital near to the operating room would be suitable. New cupboards with adjustable shelves were built into the dressing room now known as the Dispensing Room. The service room was equipped with a deep sink, a two-burner gas stove, and a large hot water sterilizer. To this was added a long work table with large drawers underneath for unsterile supplies, and a cupboard above for linen, enamel ware and other supplies. This now is the Receiving Room.

In the Dispensing Room only sterile supplies, clean equipment, and solutions for intravenous use are kept. A Dutch door, the lower part of which is always closed, bars entrance to those other than the Central Supply Room staff. All requests for trays and equipment are made on a special requisition, called an order form, by the head nurse and presented to the Central Supply Room Dispensing Room. The order form contains the name of the ward, date, article requisitioned, and signature of the head nurse. In cases when a charge is to be made, the patient's name is added to the order form which is then sent to the business office. To each tray in the Dispensing Room is attached an isinglass covered card and a service slip. The card contains a list of the articles on the tray. The service slip contains the name of the tray, the signature of the nurse who set the tray up, and the date of sterilization. There is space on this slip for the ward, ward nurse's signature, and date on which tray was used, also space where any breakages, defective or missing equipment may be noted.

The Receiving Room, as its name implies, is the section where all trays are received after they have been used on the wards. Cleaning, sterilizing and assembling of equipment is carried on here. As the trays are taken in, the ser-

vice slip, completely filled in by the ward nurse, is removed from the isinglass covered card and kept for twenty-four hours to be checked against the order form. Once every day an entry of all trays issued from the Central Supply Room is made in the daily census book. This book acts as a permanent record of the trays used, the number, and to which ward they were issued. At the end of the month these entries are totalled and the average number of trays used each day is ascertained.

The Central Supply Room in the Homoeopathic Hospital (120 beds) is set up to service all wards and departments except the obstetrical ward. All treatments and examinations, instruments for dressing trays, surgical supplies, needles and syringes, croup tents, bed sides, restraining belts, and jackets, electrical equipment, such as fans, heaters, and thermolights, sand bags, fomentation flannels, ice caps, ice collars, and rubber air rings are kept in the Central Supply Room. Equipment for oxygen therapy is dispensed from here. In this hospital oxygen therapy is administered by means of the nasal catheter and B.L.B. mask and student nurses receive instruction in this important therapy.

A graduate nurse is in charge of the Central Supply Room during the day. After 7 o'clock, the night supervisor receives all calls for trays, etc., and dispenses them. There is one student nurse in the department. She spends a period of three weeks some time after the completion of the junior operating room term. A junior student being trained in the care of anesthetic patients in the post-operative recovery room works in the Central Supply Room in the afternoon. This student spends five hours five days a week in the preparation of solutions for ward use. Such solutions as carbolic solution 5 per cent and boric solutions 4 per cent, etc., are made under supervision.

The advantages of the Central Supply Room are many. First to the teaching program it is a link between the classroom and the ward. The trays are set up for ward use in the same way as the procedure is taught and demonstrated in the classroom. This standardization has proven helpful to the head nurse and student alike especially in this hospital which is an open hospital with doctors making rounds throughout the day. To the student nurse the uninterrupted period of three weeks when she can learn the proper care and sterilization of equipment used in the hospital is an advantage over the former, often hit-and-miss, way of cleaning trays and equipment whenever she could make the time. Centralization of equipment lessens duplication of supplies thus proving an economy in the operation of the hospital. Equipment lasts longer when properly cared for, therefore, replacements are fewer. To show how breakages have been cut down, the greatly used 2 cc. hypodermic syringe is an example: the breakages in February, 1942, amounted to 14, in February, 1945, to 4. Similarly, replacements due to breakage in all articles have been reduced, so that it is felt that the initial cost of building cupboards and buying new equipment has been made up by this great saving. And to the patient — he, too, benefits by this wartime measure since centralization and standardization make for better nursing service.

Preview

Who is responsible for what in the total picture of welfare work in the community? When should the public health nurse refer cases to the social worker? What may she look for in collaboration from her colleague? These are some of the baffling points on which Lillian Thomson will throw light in her forthcoming discussion on the Public Health Nursing Page.

Contributed by Hospital and School of Nursing Section of the C. N. A

Using the Psychological Approach

CLARA R. AITKENHEAD

One of the secrets of success in clinical teaching and supervision lies in the type of approach and contact which is made between the patient and supervisor or head nurse. In the smaller school the nursing arts instructor often assumes some responsibility for the ward teaching program which, if well planned, should provide considerable satisfaction. There is a definite advantage in having the same person perform this dual function, since she can perhaps better correlate theory and practice than the busy head nurse of today who lacks time because of heavy administrative duties and may not always be qualified to assume this very important part of the student's education. In contrast to "Mrs. Chase", the patient provides the necessary stimulation for the students, and the instructor can measure the effectiveness of her classroom teaching.

There is usually some degree of apprehension on the part of the patient on admission. If it can be overcome by a satisfactory contact we have a valuable aid to efficient nursing and are assured of a favourable reaction. In the busy routine of a hospital day nurses are often too prone to forget this very important aspect; what appears simple to the student can seem complicated to the patient and arouse unnecessary fears. A few minutes spent in reassuring the patient will prove well worthwhile.

What are some of the factors that help to make a good contact? First, a friendly yet impersonal attitude. Normal individuals respond well to an interest in themselves and the sick are no exception. Dr. Osler[1] has said it is sometimes more important to know what sort of a person has the disease than what sort of disease a person has. The nurse should show a real interet in *the patient as a person*, his or her occupation, family, names and ages of children, who is caring for them, previous visits to hospital if any, interests and hobbies. This in many instances is all that is needed to break down any barrier that might exist between patient and nursing staff. It is important to learn from the patient if he has any fears, worries or questions in his mind and the nature of them. Such questions as can be answered by the nurse should be done intelligently, others should be referred to the head nurse or doctor.

Having attended to the mental comfort, emphasis is then placed on the physical well-being of the patient. In the presence of a skilled, understanding supervisor a feeling of security and confidence is built up in his mind. Small details in nursing care, which add immeasurably to comfort while a treatment is being performed, are too often forgotten.

Special interest should be shown in

the patient's physical condition, ascertaining what factors led up to consulting a doctor and why hospitalization was necessary. Some brief explanations to the patient are essential in order that he may fully understand. An outline of the prescribed treatment, what he can do towards his recovery and welfare, and the part nurses and doctors play — are all topics which can be discussed.

Students learn by various methods — classroom instruction, the morning circle,[3] conferences, ward clinics, patient care studies, clinical teaching and supervision[4] — the last mentioned being one of the most effective methods when carried out by a qualified supervisor who is keenly interested in the welfare of patients and in stimulating students to do good nursing. Observation of a nursing procedure well performed is important in the learning process, but learning by doing under proper supervision is even more important in order to develop skills. Here with a patient the young student sees and learns to meet the physical and mental needs more intelligently, to discriminate and thus use better judgment. This patient-nurse relationship also helps to foster desirable attitudes in the young student, so essential to good nursing. At the bedside the value of organization of equipment is more fully realized, nursing skills as taught in the classroom are put into practice, new techniques aer learned and mastered and, what is so often forgotten, opportunities to teach the patient present themselves. Patients who may have to do treatments at home have many questions to ask. How dependent the patient can be on instructions from a good nurse, in a way that he can understand, cannot be over-emphasized.

A great deal of the success in clinical teaching depends on the ward demonstrations being performed as soon as possible after the classroom demonstrations. In order that clinical supervision may be most effective, the student must be well prepared prior to performing at the bedside. She must have a thorough understanding of the nursing principles involved, the type of person to whom she is giving care, particularly from a psychological point of view, special precautions to take and whether or not there are specific needs to be met. The head nurse, who usually knows and understands the patient much better than the teaching supervisor, is a well qualified person to give this information.

When a demonstration is being given, the number of students who should be at the bedside will depend on several factors — the kind of patient, degree of illness and the nature of the procedure under discussion. When it is not considered feasible for a group to be present, having not more than two students at the bedside who will act as assistants helps to remove the feeling in the mind of the patient that she is being used merely as learning material. In some instances it may be considered wise to have only one student observe. If the nurses are well prepared beforehand no discussion of actual technique should be necessary at the bedside. After the demonstration by the supervisor a student who has observed carries out the treatment the next time it is due while another one looks on. While the nurse is concentrating on her technique the supervisor keeps an eye on her, and also talks with the patient, thus helping to relieve tension both on the part of the patient and the student. It is a good plan to have a third nurse responsible for the physical preparation of the patient such as draping, protecting and screening bed, adjusting light, etc., but she does not observe the procedure at this time. This allows each student to concentrate more fully on her allotted nursing care and also saves time. Later, when the student has acquired more confidence through experience, supervision of the entire procedure, including care of the patient, can be carried out. As compared with the initial performance when the student is

primarily interested in technique, the supervisor at this time can evaluate her progress and the teaching will be more effective.

If it is possible to have students perform certain treatments for the first time while they are still in the classroom, better results will be obtained since the time element is removed, as compared with the nurse who is being supervised when she is on the ward full-time and is responsible for many additional duties.

When the treatment is completed, the physical comfort of the patient taken care of, appreciation expressed for her co-operation and the equipment removed from the bedside, there follows a short conference and questions on various aspects of the procedure. The sun porch on the ward or the classroom, where the students can be seated, is a suitable place for this discussion. Reporting to the head nurse and charting completes the procedure.

Let us consider the teaching opportunities that were afforded by Mrs. X who has been admitted to a ward in the hospital, a slightly-built woman of fifty-two years, with two boys in the services, her husband and young daughter at home. She appeared very weary and listless when first seen, somewhat apprehensive but most willing to co-operate and very appreciative of the nursing care being given. Her condition is more fully described in Dr. MacDonald's article in this issue of the *Journal*. Daily catheterization and irrigation of the urinary bladder was prescribed, using 500 cc. of warm 4 per cent boracic solution. At first, as much as 1500 cc. of cloudy urine with a foul odour would be withdrawn. Then the doctor asked that she void just prior to the treatment. She would pass from 300-500 cc. and when catheterized the nurse would obtain 1000-1200 cc. of cloudy urine with a thick sediment at termination. As the infection in the bladder cleared up, the patient's appetite improved and she slept better. The amount voided at one time gradually increased, the urine appeared more normal, and the amount withdrawn on catheterization was as low as 500 cc.

While she was in hospital one of the sons returned from overseas and visited his mother. Mrs. X was very happy and on seeing her the next morning stated she could not help but feel that the mental state of an individual had a marked effect on his physical condition. The physical response to the psychological stimulus was that she started voiding unusually large amounts, and on the day following the retention was considerably less for the first time. Our patient looked an entirely different person; it was easy to see that she had been relieved of some mental strain. While it is well realized that we cannot separate the mental from the physical state, so definitely does the one affect the other, the point the writer wishes to bring out is that this comment coming from the patient spontaneously is of significance and bears out our premise. The atmosphere in the whole ward seemed brighter because of this one patient's cheerfulness, and the response to her daily treatments was most satisfactory.

Being of the same nationality the supervisor did not encounter any difficulty in gaining the confidence of Mrs. X and making a very desirable contact with a view to using her for teaching purposes.

A small group of junior students, who had not performed this procedure previously, were chosen to report to the ward three at a time on successive days, to carry out under supervision the daily treatment of this patient. This consisted of catheterization, collecting a specimen for laboratory examination and irrigating the bladder. Prior to the first demonstration a short conference was held with the students, telling as much as possible about the patient and her condition.

The supervisor performed the pro-

cedure once assisted by two students to whom we shall refer as A and B. After preparing Mrs. X mentally for the treatment B draped her, screened bed and adjusted light, while A observed the tray set up, scrubbing of hands, carried the tray to bedside and observed. The next day A performed the treatment, B observed while C draped the patient. The following day B performed, C observed and D took care of the patient. This rotation continued until all students in the group had carried out the procedure satisfactorily under supervision. The patient's confidence was so well built up by this time that she did not mind at all having a different student each day. So long, she said, as the supervisor was present she felt quite secure and the treatment was done comfortably and with safety. One of the values of teaching at the bedside is that the student learns to attend to simple details such as turning the pillow, giving a drink, and making the patient quite comfortable before commencing as well as leaving her comfortable when the treatment is finished. This is mentioned as Mrs. X expressed considerable appreciation for this care, stating that when the treatment was carried out in the absence of supervision, there was sometimes a lack of attention to these details — the draping would not always be adequate which she said was embarrassing, regardless of the fact that the treatment was carried out daily. This was brought to the attention of the students and emphasized in an endeavour to point out to them that, while this was all taught in the classroom, it was not merely something to be read and not practised, but really affected the patient much more than one would realize. Visualization in the learning process tends to make a favourable and permanent impression on the young student, and getting the patient well as *comfortably* as possibly must always be borne in mind.

At first very little actual teaching was given at the bedside. We did not know how the patient would react to verbal instructions, although she realized the students were performing the treatment for the first time. Then one day Mrs. X said that she was learning, too, and was very much interested, saying that some day she might have to do it herself. From then on a simple explanation of the treatment was made to her as we went along. Mrs. X enjoyed meeting all the different students and looked forward to our daily visit.

When our patient was about ready to go home the doctor said she must carry out her treatments for some time, and that the nurse would teach her how to do it herself. She was rather perturbed about this, the kind of equipment to use and the preparation of it. She had noted how careful the nurses were about their technique and expressed some fear regarding her ability to do it safely herself at home. The tray set up, while simple to the nurse, looked most elaborate to her — where and how would she obtain all the enamelware, sterilize it properly and not contaminate anything? This was discussed with the supervisor who gave her the reason for the rigid technique employed in hospital, how simple utensils found in the home, when cleansed and boiled, would serve the purpose, as well as method of sterilizing the catheter. A simple but safe procedure was drawn up for home use and explained in detail, in addition to preparation of boracic solution for cleansing and irrigating, and bichloride of mercury solution for sterilizing the hard rubber catheter. This type of catheter was prescribed by the doctor since it would facilitate the treatment for the patient when doing it herself with less risk of contamination. We observed Mrs. X carry out the treatment twice with the aid of a mirror before she went home and she did it very well. It was a great satisfaction to the nurses to note how effective our teaching had been. Our patient felt very happy and relieved to

feel that it was not as difficult as she had thought, and expressed her appreciation for the nursing care, encouragement and instructions given.

While in hospital Mrs. X was taught the value of sufficient rest, sleep, freedom from mental strain, elimination, posture, a well-balanced diet and plenty of water, as applied to her particular condition. She was an intelligent person and responded very well to advice.

A visit to the home by the supervisor was welcomed by the patient to look over the home set-up to ascertain if it was satisfactory. It was a simple home, attractive and meticulously clean. The only expense Mrs. X had was for an Asepto syringe, catheter, absorbent cotton and bichloride of mercury tablets. For the tray she used a cookie sheet, two odd custard dishes for cleansing solutions — using castile soap and boracic — a wide glass pint-size jar for the irrigating solution, a quart milk bottle for the bichloride of mercury solution, and an oblong enamel pie dish in which she immersed the catheter for sterilization, rinsing it by pouring boiled warm water over it. She set her tray out in the bath tub, placed a bath mat on the bottom on which to sit, adjusted a hand mirror by placing it against the glass jar, then performed the treatment which she stated soon became as simple as cleaning her teeth. When finished she cleansed and sterilized the articles used, covered the entire tray with a clean towel so that everything was ready for the next morning. When seen at the clinic a few weeks later, our patient seemed an entirely different person, bright-eyed and happy about feeling so well and pleased with the progress she feels she has made.

Interest in the welfare of Mrs. X expressed by the students, led to an invitation from her to visit her home, where she said she would show them her tray and tell how she carried out the treatment. Keen interest and enthusiasm was expressed for the simplicity of equipment, method of preparation of it, and performing the procedure. Many questions were asked and answered. Our patient seemed pleased over the inquiries made in regard to her health and family. We were shown through the home where some of her handicraft work was much admired.

On return to the hospital a short discussion followed regarding the close correlation between theory and practice, the value of teaching the patient, and, lastly, the satisfaction derived by the nurse on achieving the ultimate aim of nursing.

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An Instructors' Group that Really Functions

MARGARET O. COGSWELL

In the Edmonton District, Alberta Association of Registered Nurses, is a very enthusiastic "Instructors' Group". On the third Monday of each month, with the exception of the three summer months, eighteen instructresses from the various training schools meet to get acquainted and to discuss problems. Members from the University of Alberta and from each of the four training

schools in the city attend, and nurses from Ponoka, sixty miles south, Vegreville, sixty miles east, and Lamont fifty miles northeast, come in by train or car or bus. We visit each of the hospitals in turn, and are always warmly welcomed. This has been going on for six years and, although the personnel has been continually changing, enthusiasm has never waned. Partly, it is because we start out with dinner at six o'clock —and such a fine dinner! Here we relax and let ourselves go and really get to know one another. Everything is discussed from the weather to the latest movie.

When dinner is over, we either gather around a long table or pull easy chairs into a circle. Paper and pencils are distributed and we start work. We have been very fortunate in our chairmen. People like Laufey Einarson, Gena Bamforth and our present leader, Mrs. Virginia Pearson, are all so interested, enthusiastic and capable that they guide us and keep us from straying from the paths of business.

In September, we usually decide what our program will be for the following months. This is very elastic and when anything new crops up it receives due consideration. However, we do try to plan at least a month beforehand what the topic of study will be so that each can be prepared.

Last year we started with a discussion of the R. N. papers. A report was given by members of the spring and fall panels regarding the methods of marking the papers, the allotment of marks and the evident weaknesses there had been in teaching. In turn, members of the group weren't backward in pointing out what we considered wrong with the papers.

Our chief studies for the year were the course outlines used by the different schools of nursing, two or three subjects being taken up at each meeting. The plan was as follows: One person would outline her course in, say, anatomy. She would tell us how many hours she gave, how this time was divided, what aids she used in teaching, and the relative merits of the textbooks she used. Then a teacher from each of the other hospitals in turn would give her ideas. Each told of the differences in her plan, why she found another textbook more valuable, etc.

In January, we invited the supervisors and head nurses interested in ward teaching to meet with us in the hope to correlate the work in the classroom with that on the wards. About sixty were present. To stimulate participation, four of the instructors opened the discussion with short talks on bedside teaching; treatments and drugs—their place in the ward teaching program. One of the highlights of the year was a visit from Miss Gertrude Hall from National Office in March. She introduced a number of revolutionary ideas that stirred us up considerably

During the summer we are to put some thought on qualifying examinations for students at the end of the first year. In the fall we plan to make a study of it.

There is always so much to discuss that if we hadn't a capable chairman we would carry on far past the usual 9.15 p.m. For six years no one has been known to miss a meeting unless illness or some other major disaster has overtaken her. Each one feels that these get-togethers are so worthwhile that everything else must be set aside for that evening.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Opportunities in a Rural Hospital

JEAN WHITE

One of the biggest problems in the present-day nursing world is to get and maintain adequate staffs in the hospitals located in the small, out-of-the-way communities. This difficulty is not peculiar to any particular area. It seemed worthwhile, therefore, to do a little analyzing and to try to discover the advantages as well as the disadvantages of nursing in a small hospital in a community remote from the large, well-populated areas.

Let us consider first why hospitals are organized in thinly settled localities. Where transportation between villages and towns and larger urban communities is difficult, to have ready access to a local hospital may mean the saving of lives. While a certain level of care can be provided in the average home, there are innumerable cases of illness which require the highly skilled care available only in hospital. Most hospitals are organized and paid for *by* the communities for the benefit *of* the community. A considerable amount of local pride is developed in having as much equipment and as many services available in the small rural hospital as can be provided. Organized on this basis, the hospital sells its services when possible to patients who are able to pay and gives service, which is paid for by the community, to those who cannot afford to pay. The hospital stands ready to serve the sick as the agent of the community, looks to the community for support, and supplements public funds by charging fees to patients able to pay them.

It would appear, therefore, that there is ample justification for the establishment of small community hospitals. Who should give the nursing care in these institutions? Twenty years ago it was common practice to have a school of nursing conducted with student nurses providing the service. More recently it has been realized that, even where adequate affiliation facilities were available to supplement the training these students received, the arrangement was far from satisfactory. The community hospital was confronted with the problem of meeting the need for nursing care with a goodly proportion of their senior students absent from the home school. Gradually, as more and more of these small training schools have been closed, the call has gone out for graduate nurses to staff the wards. Tasks around the hospital which do not call for the skill of the fully qualified nurse have been delegated to ward maids and to nurses' aides. The war has brought in many of the latter, trained by the St. John Ambulance Association or Canadian Red Cross Society, who are capable of making beds, giving baths, and similar tasks which release the nurses' time for more technical services.

The number of staff nurses required for a fifty-bed hospital fluctuates in relation to the volume of skilled nursing care needed. It has been estimated that "there should be enough nurses to give an *average* of somewhere between two-and-a-half and three hours of nursing care per patient per day". What advantages has this type of hospital to offer to the ambitious young graduate? How can she be persuaded to venture far from the larger towns and cities to the small hospitals where her services are so sorely needed? People speak of "being buried in the country". What has that country to give to the nurse who is interested in looking for a full life, rich in contentment?

Perhaps the most important factor is the breadth of experience which may be secured. In a large institution the staff nurse is usually limited to one ward. In the small hospital she must be prepared to assist with all types of care, operative or obstetrical, communicable or emergent. It is an excellent opportunity to broaden her knowledge of every aspect of nursing care. Here, too, the observant nurse can learn many of the details of hospital administration, supervision of the sub-staff, filing of records, accounting, purchasing and hospital housekeeping. A better understanding of the patient is possible because the nurse knows the type of home from which the sick person has come, the type of life she leads, the family responsibilities, the financial worries, the best methods of providing for successful convalescence. In matters of health teaching, because she is familiar with the racial groups in the community, their habits, diets, etc., the nurse can accomplish very real improvements. Certainly these are advantages, *par excellence*, which the nurse limited to one ward in a large city hospital can never enjoy.

In off duty hours, what has the small community to offer for recreation? Golf, riding, tennis, frequently swimming for summer leisure; skating, skiing, badminton as winter sports. Nurses who enjoy a game of bridge will find interested friends among the townsfolk; those whose hobby is gardening will find ample opportunity and space. The radio makes up for inability to attend symphony concerts and plays. Do the majority of staff nurses in the large city hospitals go to them anyway? Book clubs, knitting clubs, nature clubs — there is no lack if the nurse will look for it. There is a sociability to be found in the small town and the rural area which is entirely lacking in the large city. The nurse can *belong*. She is not simply one small individual on a big staff — she can become a part of the active community life.

One of the voiced stumbling blocks is stated to be the smaller salaries paid to the nurses in the rural hospitals. When she stops to realize how little actual hard cash the average farmer and his family handle in the course of a year, the nurse will understand a little of the problem the rural community has in financing the hospital. I am not attempting to justify inadequate salaries but experience has proven over and over again that, even though she may receive less than her city sister, the nurse in the smaller hospital is able to save much more in proportion. For the ambitious nurse who is anxious to go on to post-graduate work, there is no better way to put money in the bank than to seek employment in a rural hospital.

It has been suggested that a possible development in the future may be to reverse the former affiliation arrangements whereby senior students from the large schools of nursing might go for a few months to some of the smaller hospitals. There is considerable merit in this plan, particularly if there is a public health nurse in the community who could introduce the student to the homes of the people and familiarize her with rural psychology. Knowing the opportunities provided in these hospitals, the

(*Concluded on page* 970)

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

An Experiment in Group Study

HESTER LUSTED

Regina's public health nurses have been organized and holding regular meetings for ten years. Officially, we are Regina Sub-section of the Public Health Section of S.R.N.A., but we more often refer to ourselves as the "public health group". This group holds meetings the first Wednesday in every month from October till May at the homes of the members. There is a short business meeting, a program, and light refreshments are served so that we have a social get-together to finish off our evening. However, the program is the main part and each year a plan is drawn up in the fall. Last season we made a study of our community and it was one of the most interesting programs we have had.

As a basis for study we used Joanna C. Colcord's book, "Your Community", published by the Russel Sage Foundation. This book was specifically designed as a guide for citizens who wished to collect facts about their community as the basis for efforts to promote better living conditions and is especially valuable to groups interested in the field of social work.

As public health nurses we realize that living conditions are inseparable from health problems so we set out last fall to find out what sort of city this is in which we live and work. Before we had gone very far we felt a bit like explorers — there were so many previously unknown facts to be discovered about Regina.

Our guide-book started us off with an explanation of how to go about our fact-finding trips and it suggested that we keep a social base map of our own community. This is a large scale map on which are affixed symbols which indicate the location of various institutions and facilities — public services, schools, churches, clubs, welfare institutions, recreation facilities and so forth. After this introduction each chapter of the book is devoted to one aspect of community life commencing with founding and development, local government, and moving on through housing, provisions for health care, educational resources, to the final chapter on community planning and co-ordination. These are just a few of the headings. There are nineteen chapters, each one covering one phase of community life, describing its purpose and value to the community, then giving a series of questions which we had to answer for our own city.

Each member of the group was assigned one topic and usually two topics were covered at each meeting. First of all, the nurse studied the guide-book, then set out to accumulate enough information to answer the questions and make out a report to be presented to the group. This usually involved interview-

ing one or more persons—the police chief the regional director of selective service, directors of social agencies — as well as making good use of the public library.

It did involve a good deal of time and work on the part of each member as she prepared her topic, but it was most certainly interesting work and every one of us felt that we could have spent more time and got more information on our assignment. By the time we came to the end of our meetings for the season we felt that we had learned a great deal and would like to go on and become still better acquainted with community facilities.

Our only suggestion to any group undertaking a similar study is that they assemble their reports into some sort of file or loose-leaf book in order to have a permanent record of the information gathered. We feel that we could use such a book as a reference, and it would be especially valuable to a nurse commencing public health work.

Disease Incidence Up

Tuberculosis and syphilis are the two most important health problems of liberated Manila, according to Epidemiological Information Bulletin No. 15 released by UNRRA. Based on returns for the first three months of liberation, the death rate for pulmonary tuberculosis as for a year has been calculated at 800 per 100,000 inhabitants, or about twenty times that of the average American city. In ten weeks, 2,045 new syphilis cases were found among the civilian population, and the incidence continues to increase. Gonorrhea is equally prevalent. Manila was one of the few cities of tropical Asia where malaria had been reduced to a low level. During the Japanese occupation the disease returned and it now constitutes a serious problem. There has been no significant increase of other epidemic diseases.

War-shattered cities in continental Europe are also suffering from serious epidemics. Pulmonary tuberculosis mortality has more than doubled in Rome. Epidemics of bacillary dysentery of a severe type and of typhoid fever are spreading in Berlin, where diphtheria, too, is once more on the increase. There were 1,100 cases of typhoid fever during the first three weeks of August. At Helsinki, Finland, there have been 2,472 paratyphoid fever cases up to September 6. Diphtheria remains widespread in the Netherlands where now one-half of the cases occur among adults.

—*UNRRA News.*

Rural Hospitals

(*Continued from page* 968)

nurse upon graduation will be better prepared, and, possibly, more prone to accept positions there. Until some such plan as this is evolved, the problem of securing adequate staff for the small community hospital remains on the doorstep of the general nursing group. The advantages far outweigh the possible disadvantage of isolation. Let's go to the rural hospitals!

Multiple Births

It is true that seven infants at one confinement have been recorded. There are six instances of sextets, thirty of quintuplets. Quadruplets occur once in every half million births. Triplets occur once in every eight thousand births, while twins are much more common and occur once in every eighty to ninety births. The probability of premature delivery in multiple births is more than three to one. The incidence of toxemia and antepartum hemorrhage is also higher.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

The "Two-Year" and the "Four-Year" Nurse

In recent discussions of the possibility of preparing three types of nurses (the assistant, the clinical, and the teaching nurse), periods of training of one, two, and four years have been suggested. Obviously, these lengths of time were approximate, and not meant to be exact to the month. It was suggested, however, that there is no real evidence that three years is the perfect length of time for educating any, let alone all, nurses; and to discuss courses, it was necessary to suggest lengths of time, which would necessarily differ in different lengths of training.

One objection to the "two-year nurse" has been expressed as follows: "She may not know enough about the reasons involved in the adequate care of the patients." It is unfortunately true that the present three-year nurse does not always know enough of these reasons; such comprehension, however, is more dependent on the selection of the students of nursing and the use that is made of their experience than on time "put in" on certain wards. Certainly there is a necessary length of experience but it is suggested that two years may be found long enough when the purpose is definite and the conditions favorable. At least the plan is worth a trial. If the course which has been suggested for the clinical nurse is examined, it will be found to contain five months experience in medicine, which is the maximum suggested by the Canadian Nurses Association Curriculum of 1932, and four months in surgery, which is one to two months less than suggested by the Curriculum. It contains, in addition, the experience in mental hygiene and psychiatry, in communicable disease, in pediatrics and in public health, which are required by the Canadian Nurses Association, and which surely contribute to understanding of the patient's needs, but which are more frequently than not omitted from the present three-year courses. The times suggested for these latter experiences are not as long as those in the Canadian Nurses Association Curriculum, but at least they are to be included; and we *are* suggesting a shorter course. We are suggesting, also, one which is not striving, unsuccessfully, to put in more and more from all the fields of nursing; but which is concentrating on producing a good clinical nurse.

Doubts as to the "four-year nurse" have taken this form: "She is to be trained in specialties and, not having much experience in direct care of the patient, will not be capable of directing the two-year nurse in good bedside nursing which is so important." This criticism expresses a complete misapprehension of the suggested four-year course. Its object is to produce a better nurse, not a worse one. In introducing the plan this statement was made: "We are accepting the (present) assumption

that public health nurses should be qualified bedside nurses, and we are adding to this the assumption that all teachers of nursing should be qualified public health nurses . . . at the conclusion of this course the student will be qualified for *general staff nursing* in either the hospital or the public health field; and will have some practice in either field, or preferably in both (after graduation) before going on to teaching or administrative work in either one." Her preparation for supervision and teaching is to be given on a foundation of thorough training in truly general nursing—that is, in bedside and in public health nursing. The statement "she is to be trained in specialties" seems to imply that she is to be trained *only* in specialties. Nothing could be more untrue either of the suggested plan or of the one demonstration of it which is in progress in this country. The nurse we are discussing is to have a more, not a less, thorough training in nursing than the three-year nurse has today; she is to study and practice *nursing* in its several branches for four years. Moreover, public health and psychiatry are no more specialties than medicine and surgery, and, as previously pointed out, they are supposed to be part of a proper training for nursing in Canadian schools. Does anyone seriously contend that a student will become a better nurse because she has been denied these essential experiences in order that she may become an economic asset by servicing a medical or surgical ward for which proper nursing service has not been provided by the institution which is responsible for doing so? The nurse whose "education" has been limited to medicine, surgery and obstetrics is the nurse who has "specialized", prematurely, and to the detriment of her whole future career.

Finally, there has never been a suggestion that a satisfactory nurse could be prepared without "having much experience in direct care of the patient." The four-year course as suggested (and demonstrated) involves direct contact with the patient in every year. This is however, contact with all types of patients, in the hospital and outside it; and content the full implications of which are brought out by skilful instruction.

Already a certain number of the products of such a course are being tested in the practice of nursing. The reports of patients and employers do not suggest that they lack nursing ability, or fail to grasp the reasons behind treatment. The four-year nurse can be prepared to nurse patients, and to teach others to do so.

Working with Newspapers

Nursing organizations, public health departments, alumnae associations, in fact every branch of nursing at one time or another wishes to make use of newspaper publicity. There are frequent moans and groans when what appeared to the writer to be a perfectly sound article or story is cut down almost to the vanishing point. Usually, nurses have not had a great deal of experience in interpreting their work to the public by way of the press. Everyone who has occasion to do this kind of writing will welcome a recent publication of the National Publicity Council, "Working with Newspapers". The author, Gertrude Simpson, is an experienced journalist who has had charge of publicity work with various welfare organizations. Her sound advice on how to get and hold reader interest, how to know what phase of the agency program is news, how to work this news into the right department of the newspaper, how to find out how effective the newspaper publicity is, make this one of the most useful handbooks available. The price is only 75 cents and the Council's address is 130 East 22nd St., New York City.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

General Meeting — 1946

The biennial meeting of the Canadian Nurses Association will be held July 1-4, 1946, inclusive, with June 29 and July 5 given over to meetings of the Executive Committee. The meetings will be held at the Royal York Hotel, Toronto. Watch for future announcements regarding this meeting.

Personnel Policies and Practices at Home and Abroad

We are pleased to note the inclusion, in this issue of the *Journal*, of a copy of the report of the Australasian Trained Nurses' Association personnel policies, as contained in the September, 1945, Journal of the Royal Victorian College of Nursing. The nurses of Australia have, in this excellent presentation of living and working conditions as they concern every branch of nursing, set a pattern which nursing organizations in other countries might very well emulate.

A beginning along this line has already been made by one of the provincial associations in Canada by the setting up of personnel policies, salary schedules, etc., in respect to hospital nursing. Such foresightedness is most timely, especially in view of the increasing unrest among members of the nursing profession regarding hours of work, remuneration, etc., and in view of the movement among labour unions to attract nurses to affiliate with these unions. It, therefore, behooves every nurse to become informed of the plans of her provincial registered nurses' association for securing satisfactory working and living conditions.

State Aid for Post-Graduate Study

The following announcement, entitled "Open Scholarships for Tutors", appeared in the October 6, 1945, issue of the British *Nursing Times*:

The nursing profession will welcome the announcement that the Ministry of Health is offering financial assistance to nurses who wish to qualify as sister tutors and male tutors. The scholarships will cover training and examination fees, and will also include an allowance of £150 for the period of training, payable monthly in arrear, towards maintenance, cost of books and travelling expenses. These scholarships will allow nurses to support themselves while they qualify without incurring debts in the form of loans, etc. Holders will be required to give an undertaking that they will serve as qualified sister tutors for at least two years, assuming that they pass the examination. They must have had three years post-registration experience in hospital, and must apply to the Secretary, Ministry of Health, Division 4A (8), Whitehall, London, S.W.I. We regret that the three years experience must be "in hospital". Experience outside hospital is broadening and invaluable to the teacher, who will not only prepare nurses for institutional work.

This information may be used to good advantage by those who are seeking to inform members of the government and the public on the need for financial assistance for nursing.

Nation-Wide Action in Field of Nursing

A comprehensive program for nation-wide action in the field of nursing in the United States has been prepared and issued in booklet form by the National Nursing Planning Committee of the National Nursing Council for War Service. This was prepared as a blueprint for action and it is pointed out that in order to make the program, as outlined, effective, all state and local groups must participate. Comments, suggestions for readjustment and criticisms are invited by the Planning Committee.

It is suggested that small groups should be formed to study the proposals and to assist in launching plans for projects suggested in the outline. It is also pointed out that the program outline is not a finished product. It must constantly grow and change to meet the needs as they develop rapidly during the transition period ahead.

Report of the Committee on the Training of Nurses for the Colonies

Several copies of the Report of the Committee on the Training of Nurses for the Colonies, recently published by His Majesty's Stationery Office, London, have been received by National Office. The committee responsible for the report was set up in November, 1943, to examine the question of the training—both in Great Britain and overseas—of nurses who are to serve in Colonial territories, and to make recommendations, having regard also to the need in those territories for increased public health activities and for the fostering and development of community welfare. The committee consisted of the chairman, Lord Rushcliffe, a vice-chairman and fifteen members, six of whom were nurses. The report gives a short history of the growth of medical and nursing services in the Colonies, and makes wide and detailed recommendations for future development.

Copies of this report are being secured from the United Kingdom Information Office, Ottawa, and will be supplied to all provincial associations.

Clothing for Nurses of Holland

The response to the appeal for coats and capes, etc., for the nurses of Holland has been most gratifying. At the time of going to press, several boxes containing 958 coats and 273 capes were packed and ready for shipping on November 1. Indications are that we shall not only reach our objective but shall go over the top.

The International Council of Nurses has written requesting that we consider the possibility of sending food parcels to individual Dutch nurses. It was stated that individual packages, sent parcel post, reach their destination without loss, although the time required is approximately six weeks from mailing date. The following suggestions were made as to contents: soap, rice, Klim, powdered coffee, tea, chocolate, jam or jelly, Spam, salt and dehydrated soups.

Lists of names and addresses of Dutch nurses are being obtained and will be supplied to the provincial associations. Enquiries should be made from the executive secretary of the provincial association as to details of procedure.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

Nursing Sisters Return to Civilian Life

Nursing sisters are being demobilized. As they return to Canada, we are so happy to see them again and, in spite of hardships and strain to which they were subjected in theatres of war, they look remarkably well. While they speak with spirit and satisfaction regarding their experience overseas, they express their eagerness to get settled into civilian nursing life again.

The brochure which was prepared by your Postwar Planning Committee evidently has served its purpose. Many nursing sisters have spoken of its instructional value in providing information regarding rehabilitation benefits, service opportunities, and university courses available in Canada. Many letters of thanks have been received by the secretary of your Committee, extending thanks to the C.N.A. for the guidance provided in this valuable document of information. It is gratifying that the preparation of this material has been a worthwhile effort.

It must be realized that after four or more years in military service abroad, divorced from civilian nursing, nurses upon their return to Canada find themselves unfamiliar with conditions. War has brought about so many changes, unknown to them, and they feel the need of orientation. A process of adjustment is inevitable.

There is sufficient evidence to indicate that the adjustment which returned nurses must make varies with the individual. It would seem to depend upon interests, past nursing experience, previous specialization, if any, and to what extent preliminary thinking has been done as to a plan for the future.

Several nurses have considered themselves fortunate in securing desirable positions immediately upon demobilization. The positions which they desired were waiting for them. Others decided to take advantage of the educational benefit plan for veterans provided by the Federal Government for post-graduate work.

One hundred and sixteen returned nurses are enrolled in the several university schools. While the largest number are taking courses in public health nursing, there is a substantial enrolment in administration and teaching in hospitals and schools of nursing. Concentration on lectures and study is a vastly different experience to active service overseas, and while some confess the difficulty of adjustment, from observation and report, they are settling into their new situation with the same earnestness and spirit that characterized their services overseas. One student is quoted, "I wish I had taken post-graduate work before going overseas — sociology, economics, psychology and principles of teaching would have helped me a lot".

Many nursing sisters not yet demobilized are preparing to undertake post-graduate study next year. Guidance which they have received and acknowledged as to what nursing work would be most purposeful in the interval is expressed in the following excerpt:

I took your advice and reported to the Victorian Order of Nurses in Ottawa. I

am going to Toronto for the two-month course and then will be posted to a district. I appreciate so much your suggestion that I apply to the V.O.N. for experience this year.

A number of nursing sisters were unable to enrol this year and there is concern as to whether some of this number may be deprived of the educational benefit because of the clause which states that educational courses must be started within fifteen months from the date of discharge. This same factor may again operate in the case of the large numbers who have signified their intention of attending universities next year and may not be admitted because of lack of accommodation. In the light of this possibility, the following resolution passed by the Canadian Hospital Council is most timely:

Rehabilitation Courses for Nurses: Whereas there is not only a serious shortage of graduate nurses on hospital staffs but there may also be some difficulty in providing adequate post-graduate facilities for those returning nursing sisters who desire to take special courses;

Be it resolved that the federal government be respectfully requested to permit returning nurses desiring to take post-graduate courses to postpone this utilization of rehabilitation funds for up to two or three years from discharge. It is further suggested that the granting of such postponement of rehabilitation aid be made contingent on the nurse being employed in the interval in that field in which she proposes to specialize.

In support of this resolution, the Postwar Planning Committee has also submitted a resolution to the same effect, and it is hoped that before this issue of the *Journal* appears the resolution will be approved by the Executive Committee of the C.N.A.

Some returned nurses tell us of their indecision and frustration in undertaking post-graduate work immediately upon their return, when civilian and D.V.A. hospitals are in such urgent need of nurses. However, in taking the long distance view, shortage of graduate nurses for hospital nursing service has been an unsolved problem for years and it would seem short-sighted if veteran nurses who are eligible did not appreciate and take advantage of the exceptional opportunity afforded to them to undertake special preparation for executive positions in the fields of their choice. In the end, nursing will profit more, and the nursing profession will be richer in leadership.

It has been assumed in several quarters that nursing sisters, upon demobilization, should volunteer in the services in which shortage of nursing personnel has been most serious, particularly tuberculosis and psychiatry institutions. If this expectation be not realized, it should not be considered as due to "total indifference" as to their "path of duty". Careful reflection is necessary. Can we expect that a substantial number of nurses will volunteer for service in any field in which they have not had a basic preparation? Many of us can turn the question to ourselves, and admit that in our own experience we have refrained from entering unfamiliar fields. Viewing the situation broadly and objectively, do we not have to acknowledge that the fundamental reason for the apparent lack of interest, on the part of many nurses, in the fields of tuberculosis and psychiatry goes back to the administration of the undergraduate course which, in many instances, does not provide for a basic experience in these important and essential nursing fields? No one can dispute the fact that the development of a positive attitude, and a desire to nurse and specialize in these particular services, can be best brought about by a basic experience that is challenging and satisfying. Wartime problems in nursing have accentuated this weakness in nursing education and it is hoped that, in the revision of our national cur-

riculum to meet rapidly changing and increasing nursing demands in a postwar era, serious consideration will be given to what must be included as essential nursing experiences.

At this time of demobilization when nurses are making decisions as to what preparation they need for reinstatement into purposeful employment, they should be made aware of the increasing demand for the clinical nurse specialist. University schools are offering their co-operation in developing sounder post-graduate clinical courses and they are gradually being organized and administered on an advanced level to prepare experienced nurses for teaching and administrative positions. Graduate nurses who are eligible should be encouraged to prepare themselves to take charge of clinical departments of nursing, and to many demobilized nurses this development should offer new openings for satisfactory civilian nursing service.

MARION LINDEBURGH
National Chairman
Postwar Planning Committee,
C. N. A.

The Australian Nursing Scene

Nurses in all parts of Canada who are serving on committees for the consideration of the various factors involved in working conditions for nurses will be very interested in the comparable developments in the Australian nursing scene. As reported in the September, 1945, issue of *Una*, the journal of the Royal Victorian College of Nursing, at the second annual meeting of the Employees' Association of the R.V.C.N., a comprehensive report was presented dealing with suggested salaries, hours of work, etc. While no action has been taken on this report as yet by the Hospital Nurses' Board, the recommendations show the trend to be toward the improvement of working conditions. Titles and terminology differ from our customary phraseology but the intent is the same. The following are the principle recommendations with explanatory terminology in brackets:

INSTITUTIONAL NURSES

1. *Increase in Salaries*: Sister tutors (instructors): 1st yr., £5 — 2nd yr., £5/5 — thereafter, £5/10. Sisters (supervisors): 1st yr., £5 — 2nd yr., £5/5 — thereafter, £5/10. Staff nurses: 1st yr., £4/5 — 2nd yr., £4/10 — thereafter, £4/15.

2. *Days off to accumulate*: That each employee on the day staff be allowed off duty one day each week, provided that by agreement with her employer such days off may accumulate and be taken in one continuous period at a time mutually agreed upon between the employer and the employee. That the period during which her leave may accumulate shall not be in excess of three weeks.

3. *Annual leave for staff nurses*: That staff nurses be granted four weeks holiday.

4. *Notice of annual leave*: Unless by mutual agreement, notice of annual leave be given to all members of the nursing staff at least one month prior to commencement of leave.

The following reasons were given in support:

Sister's salary: That in view of the responsibility involved in the position of sister, and the proposed increase of salary of staff nurses, it is considered that the salary recommended is the minimum salary which should be paid to a sister.

Sister tutor: The same reason applies to sister tutors. Upon the sister tutor much of the important responsibility of the early training of nurses depends.

Staff nurses: That the existing rate of salary for staff nurses is totally inadequate and allows no possibility of providing for old age.

That in view of the present rate of salary ruling for female attendants under the Hospital and Benevolent Asylum Attendants Board, i.e.: 1st year, £3/8 — 2nd year, £3/9 — thereafter, £3/10 (less 16s. for board and lodging); strong disapproval was expressed of this injustice to qualified nurses, which fact it is considered must ultimately affect recruitment of nurses.

Staff nurses, particularly in private, intermediate and community hospitals, play a very important part in the efficient working of the hospital and their work should receive adequate remuneration.

Charge positions available to nurses in hospitals are limited; consequently the majority of nurses, particularly on the staffs of private, intermediate and community hospitals, remain "staff nurses" for many years, yet upon these nurses depends so much of the good nursing carried on in these particular institutions.

Infant Welfare Nurses

Sister Infant Welfare Centre (public health nurses) — Uniform salary of £6 per week.

1. *Part-time*: A part-time nurse shall be paid in respect of any part-time work not less than £1/5 per day or a proportionate part of the ordinary rate prescribed for a permanent nurse for an ordinary week's work, whichever is the greater.

Where a part-time employee is necessarily absent from her usual place of residence on account of her duties she shall, in addition to the wage prescribed, be paid 10s. for each night so absent. Such additional sum shall be deemed to include allowances for board and lodging.

2. *Casual*: A casual nurse shall be paid not less than 4s. per hour with a maximum of 30s. for each day she is called upon to work.

3. *Hours of work*: (a) The number of hours which shall constitute an ordinary week's work shall be 38; (b) work done in excess of 38 hours shall be overtime; (c) a day shall consist of 7 hours duty time.

4. *Annual leave*: Each employee shall be entitled to eighteen days annual leave on completion of each year of service without deduction of pay.

5. *Uniform allowance*: An employee after three months continuous service shall be entitled to a payment of £5 as a uniform allowance, and on the completion of the first three months in each and every subsequent year of service she shall be entitled to a further uniform allowance of £5. The cost of laundering all uniforms shall be paid by the employer.

The following reasons were given in support:

Hours of duty: In support of the request for reduced hours of work it is contended that the nurse in industry must conform to conditions provided by any Award, Determination or Agreement for the general body of employees in the industry in connection with which they are employed. Consequently infant welfare nurses should be granted the same hours of work as other municipal officers, i.e., 38 hours working time.

That the nurse engaged at an infant welfare centre does not complete her duties when the centre officially closes — she has her reports to write and entry of daily records which are important and must be kept for the purpose of statistics for the Government Statist. In addition, she has the centre to set in order and miscellaneous duties to perform before being free to leave.

Salary: It is contended that all sisters engaged in infant welfare centres, etc., have an equally high responsibility and consequently should receive the same salary.

That the duties of the nurse engaged in infant welfare centres include teaching and training of mothers, which should be recognized as a very exacting educational as well as a nursing service.

That the nurse engaged in infant welfare work has to provide her own board and accommodation which, owing to high cost of living, cannot be obtained at 30s. per week.

That the nurse carrying on the work of an infant welfare centre is actually a pioneer in the field of preventive medicine. She has the added responsibility of recognizing as such the healthy and the sick child and has to advise the mother when medical attention is necessary. Therefore to be in a position to give this advice she must have highly specialized knowledge in the health of children.

That, unlike the institutional nurse, she

has to spend time in travelling to and from the centre.

It is contended, by nurses engaged in infant welfare work, that a serious anomaly exists as no provision for part-time workers is made unless they are to be regarded as casual employees. If this be so they are entitled to 28s. per day, whilst a nurse coming under Clause 6 (*b*) of the Determination receives less than £1 per day. The latter nurse has no compensation for loss of time or long travelling hours, and the conditions are far more arduous than for a part-time worker for one municipality or employer.

Industrial Nurses

Salary: It is recommended that the salary of the nurse engaged in the industrial sphere shall be as follows: 1st year, £5 per week, with annual increments of £13 (5s. per week) until the nurse receives a salary of at least £6 per week.

The following reasons were given in support:

Salary: That in view of the high cost of living and based on the salary of the sister on the staff of a hospital, the rate of salary granted is not adequate. Further, the nurse in industry should receive annual increments as provided for nurses in institutions. It is contended that, as in the case of the institutional nurse, the value of the nurse in industry increases with her years of service. That, unlike the institutional nurse, she has to spend time in travelling to and from her work.

Other Improvements

It was ascertained that, in connection with a course in post-graduate training, trained nurses were working junior to the nurses who were not general trained nurses. Through the efforts of the Employees' Association this practice has been rectified; also in the same institution, post-graduate students now receive the salary of the staff nurse.

Risk allowance: The question of risk allowance was discussed briefly by the Hospital Nurses' Board but it was contended that this would be difficult to determine as, through the various wards of hospitals, patients might be found to be suffering from some specific disease. Until able to be transferred to a special hospital various nurses might attend the same patient throughout the day. Then it was contended that, in the infectious wards as every precaution is taken by the nurse, the risk is less than in the general ward where the disease may not be detected. Further as the outcome of the proposals put forward by the Student Nurses' Association, it is anticipated that compensation will be paid to nurses who contract tuberculosis or some allied disease in the execution of their duties, and this should to a great extent meet the situation.

Other Proposals Brought to the Board

Roster of hours: In view of complaints received that in many instances due notice of off duty hours is not given, thus preventing the nurse from making any plans for recreation, it was decided to approach the Community and Private Hospitals' Associations asking them to bring the matter before the members of their associations. The committee suggested that a clause be inserted in the Determination to cover such, but it was decided after considerable discussion at an extraordinary general meeting to try other means rather than enforce its observance through the Determination of the Hospital Nurses' Board.

Another matter brought to the notice of the Board for consideration was the position which may arise in regard to the salary paid to the sister who acts for the matron when she is off duty. It was pointed out by a matron that, where a sister is required to hold three certificates in connection with her duties and take charge while the matron is off duty, she receives payment for additional certificates and in addition special rates "at call" thus receiving the same salary as the matron.

Members of the committee felt these suggestions should receive the utmost consideration, but were of the opinion that they were so far reaching they should be dealt with and considered in the planning of post-war nursing construction.

Interesting People

On October 1, 1945, **Helen Margaret King** was appointed assistant director of the Vancouver General Hospital School of Nursing, replacing **Catherine Clibborn**, who, after occupying that position most successfully for two years, resigned to be married.

Miss King was born in Middlesex, England, where she received her early education. After graduating from the school of nursing of the Vancouver General Hospital in 1927, she occupied several important positions in her own School, at the Tranquille Sanatorium, and at the hospital at Williams Lake, B. C. In 1942-43, she enrolled for the course in teaching and supervision at the McGill School for Graduate Nurses, returning to the Vancouver General Hospital as clinical instructor in the obstetrical department. Miss King lives with her parents in Vancouver, where much of her spare time is spent in gardening and very excellent cooking.

By her outstanding teaching ability, her interest and enthusiasm in the welfare of the students, and her unusual power of adaptability, Miss King is making a fine contribution to nursing at its best. Her appointment is of great interest to the members of her Alumnae Association and to her many friends who wish her every success in her new position.

Bridgman's Studio, Vancouver

HELEN M. KING

Helen Mildred McDonel was recently welcomed to the Winnipeg General Hospital School of Nursing as their first educational director. Her work includes responsibility for the planning of all class schedules; organization of courses of study; planning for faculty conferences and teaching.

Born in Ohio of Welsh parentage, Miss McDonel received her B.A. (*cum laude*) from Wooster College. After an interval of high school teaching, she launched upon her nursing career, graduating from the D. Ogden Mills School of Nursing, Nudeau, N. Y., in 1928. For the following seven years Miss McDonel was instructor in and supervisor of pediatric nursing in the Western Reserve University School of Nursing, Cleveland, Ohio. She later associated herself with the nursing education programs in other universities, first, at the University of Denver, Colorado, where she was also assistant dean at the Children's Hospital School of Nursing. In 1940, Miss McDonel received her M.A. from Western Reserve University and afterwards was assistant professor of nursing and assistant director of the Out-Patient Department, Medical College of Richmond, Virginia. Immediately prior to coming to Winnipeg, Miss McDonel was educational director in the Methodist Hospital, Indianapolis, Indiana.

Added to the assets from this broad experience, Miss McDonel has served on the Committee on the Care of the Child, National League of Nursing Education, and has taken an active interest in state nursing association work. We welcome her to Canada and trust in her present busy life she may find opportunity to

HELEN M. MCDONEL

Boris Studios

FLORA A. GEORGE

pursue her chosen avocations of music, art, and outdoor activities.

Flora Aileen George, who until recently was matron of Ste. Anne's Hospital (Department of Veterans Affairs), Ste. Anne de Bellevue, P. Q., has been appointed to the position of superintendent of nurses at the Verdun Protestant Hospital. Miss George, a graduate of the Sherbrooke Hospital School of Nursing, took the course in teaching and administration in schools of nursing at the McGill School for Graduate Nurses. Later, she became lady superintendent of the Woman's General Hospital in Montreal, a position which she held for eight years until she was appointed director of the Nursing Service Bureau sponsored by the R.N.A.P.Q. For two years she rendered valuable service as general superintendent of the Victoria Public Hospital in Fredericton, N. B.

Miss George is actively interested in the work of nursing organizations and has served the R.N.A.P.Q. as a member of the board of managers, and of the board of examiners, as well as chairman of the Hospital and School of Nursing Section. Her many friends wish her all success in the important task which she has undertaken.

Margaret Irene Brady has recently severed her connection with the Child Welfare Association of Montreal to assume the duties of supervisor of nurses with the Department of Health of the City of Westmount, P. Q.

A Nova Scotian, Miss Brady received her B.A. from Acadia University, Wolfville. She graduated from the Royal Victoria Hospital School of Nursing, Montreal, in 1932. The following year, on a scholarship for post-graduate work provided by the R.N.A.P.Q., Miss Brady took her course in public health nursing at the McGill School for Graduate Nurses.

Miss Brady has served her provincial nurses' association as chairman of the Public Health Section and as convener of the Publicity Committee. At present she is vice-chairman of the English-speaking chapter of District 12 of the R.N.A.P.Q.

Edith Irene Stocker has been appointed as superintendent of the General Hospital, Kelowna, B. C., combining the functions of administrator and supervisor of the nursing services.

A native of Manitoba, Miss Stocker graduated from the Winnipeg General Hospital in 1924. For six years she served as night supervisor and assistant superintendent at the General Hospital, Moose Jaw, Sask. In 1932, developing her special interest in tuber-

MARGARET L. MOAG

culosis, Miss Stocker obtained the certificate given by the Saskatchewan Anti-Tuberculosis League and was appointed superintendent of nurses at the Sanatorium in Saskatoon. In 1936, she became supervisor of the Vancouver Unit of the Division of Tuberculosis Control, which position she relinquished to become field secretary with the Canadian Tuberculosis Association. Further study at the University of Toronto School of Nursing was rewarded by a certificate in hospital administration. With this additional preparation, Miss Stocker became superintendent of nurses at the Sanatorium, Ninette, Man.

Miss Stocker has always taken an active interest in association activities in Saskatchewan, Manitoba and British Columbia. She is an enthusiastic golfer and a devotee of motoring.

LOUISE DRYSDALE

Culminating a long and exceedingly useful career, **Margaret Laura Moag** is tiring at the end of the year from the position she has occupied since 1923 as superintendent of the Greater Montreal Branch of the Victorian Order of Nurses.

A graduate of the Kingston General Hospital, Miss Moag served with No. 3 Canadian General Hospital in France and in other hospitals in England during the first World War. After demobilization in 1919, she accepted a post with the Soldiers Civil Re-establishment Service in Ottawa and remained there until coming to Montreal. Miss Moag's interest in public health nursing antedates her war experience. A graduate in public health of the School of Applied Social Sciences of Western Reserve University, Cleveland, she was on the staff of the Detroit Department of Health for several years.

Miss Moag's contributions to nursing have been many and varied. She has served on numerous health and social service committees, has been president of the Registered Nurses Association of the Province of Quebec and, in national nursing, was chairman of the Public Health Section and second vice-president of the C.N.A. She was one of the delegates representing Canada at the International Congress of Nurses at Helsingfors, Finland, in 1925 and again in 1937 at London. During the latter visit, she had the honour of being presented to Their Majesties, Queen Elizabeth and Queen Mary, at Buckingham Palace. She is also an active member of the Business and Professional Women's Club in Montreal.

Miss Moag will be greatly missed from Montreal when she returns to her home in Smiths Falls, Ontario, where she plans to devote some of her time to her music—she was an accomplished pianist years ago—catch up with her reading, and do a bit of gardening. May her years of retirement be full of happiness for she leaves a job well done.

Louise Drysdale has retired from the nursing profession to take over the ownership and management of the Willingdon Tea Room in Vancouver. Trained at the Royal Columbian Hospital in New Westminster and the University of British Columbia, for nineteen years Miss Drysdale was a public health nurse in Vancouver schools and, for the last few years, was supervisor of Unit No. 2 of the Metropolitan Health Service, Vancouver.

New kinds of contacts with the public, struggles with rationing and government controls, in fact all the variety of the business world are providing much interest and stimulation for her.

Ellen E. Love, M.B.E., has retired from the position of superintendent of nurses at the Fort Qu'Appelle Sanatorium. Miss Love, who was born in Seaforth, Ontario, is a graduate of the Winnipeg General Hospital. Following service in the first World War, she joined the nursing staff at Fort San. When the Saskatoon Sanatorium opened in 1925, Miss Love became the first lady superintendent. For the past ten years she has held this position continuously at Fort San. In 1943 Miss Love was awarded the M.B.E. and this year has accepted an honourary life membership in the Saskatchewan Registered Nurses Association.

At a dinner held in her honour at Fort San, tribute was paid to Miss Love for her faithful service with the Saskatchewan Anti-Tuberculosis League; guests were members of the staff who were associated with her. Her many friends and colleagues wish Miss Love all happiness and good health in her retirement.

Anna Connor has resigned from the staff of the Public Health Nursing Division of the Department of Public Health, Toronto. Miss Connor graduated from St. Michael's Hospital School for Nurses. Previous to entering the public health nursing field she did private duty nursing and was assistant registrar at the Central Registry for Graduate Nurses, Toronto. Miss Connor had a broad experience in district public health nursing, in hospital health services, and as district superintendent. She has guided many nurses, both students and staff, in a kindly way, and a wealth of good wishes are extended to her that she may enjoy, to the full, the years ahead.

Obituaries

Madeline Anderson died recently in Moose Jaw. Miss Anderson served as a nurse during the Boer War, in which she received wounds, and in World War I. South African War veterans had charge of her funeral.

Mrs. Anna Mary (Murray) Ross died on September 24, 1945. Mrs. Ross was a graduate of Mt. Clemens Sanatorium, Michigan, and she nursed for a number of years both in Saskatchewan and British Columbia.

Gladys Young died on September 5, 1945, in Halifax, N. S., after a lengthy illness. A graduate of the Class of 1922 of the Victoria General Hospital, the late Miss Young was a highly esteemed and valuable member of the hospital staff, having acted in the capacity of head nurse on the third floor of the Private Pavilion for four years. She was later appointed as night superintendent of the main hospital, which position she held for nineteen years until the time of her retirement in May, 1944.

STUDENT NURSES PAGE

The Student Nurse and the V.O.N.

A. Elizabeth Scoones

Student Nurse

School of Nursing, Vancouver General Hospital, B.C.

Student nurses are very fortunate when they have an opportunity for affiliation with the Victorian Order of Nurses. Experience with this national order of public health nursing is of great value in developing interests and understanding outside the immediate care of patients in hospital. But it does not end there. It gives a very valuable introduction to the field of public health.

The Victorian Order of Nurses, now nearly half a century old, has for its primary objective the giving of bedside nursing care in the home, combined with health teaching. It is of great service to the community, caring for the health needs of the rich and poor alike, regardless of race, colour, or creed. It works in close co-operation with the hospital, and the various community health and welfare agencies. All cases nursed by V.O.N. staff must be under the care of a physician who, of course, prescribes all medication and treatment.

Every morning shortly after 8 o'clock, after the day's cases were listed and their records sorted out, the fleet of V.O.N. cars would leave the headquarters, each with one or two public health nurses and a student. The familiar black bags containing all necessary equipment would not be forgotten. The day's work was always carefully planned to conserve gasoline and prevent waste of nurses' time. Off we would go driving through sections of half asleep city to the district.

First there were usually diabetic hypos to be given — perhaps to an old Chinaman living in a wobbly rooming house, or perhaps to a busy little housewife anxious to learn how to do it herself. Then there would be the maternity cases—home confinements are rare nowadays because hospitals are more convenient for the doctors and for the patient. However, there are some mothers who are only too glad to be home after a few days in the hospital and let the V.O.N. do the rest. This care consists of bathing the baby in the presence of the mother, explaining every step, then giving obstetrical and general care to the mother. Many young mothers are very grateful to the V.O.N. for coming in for three or four mornings to bath the baby and explain the important points in new-born care. The rest of the morning would be spent in giving general care to a variety of patients. To an old age pensioner who had had a stroke, we would give a bed bath and an enema explaining to his wife facts about his diet, elimination, and the care of his skin. For an old lady with advanced carcinoma of the breast we would change her dressing and make her comfortable. There would be arthritic cases and many other types of medical and surgical patients. They are all appre-

ciative and wonder about paying for the service. For those who can afford it, one dollar is charged per nursing visit but there is a sliding scale for those who cannot pay in full. The V.O.N. does not rely on the fees of patients for carrying on the work as civic and governmental authorities and the community chest make annual grants.

The afternoon would be spent largely in giving pre-natal advice on matters of diet, exercise, elimination, signs and symptoms of complications, and preparation of the baby's equipment, to the expectant mother. These patients are all urged to have early regular medical supervision. Then there are the babies to weigh and the mothers to be advised about breast feeding, baby rashes, weekly gain, etc. New-born supervision is given until the baby is six weeks old and ready to attend well-baby clinics. Often there would be a sick child to go and see. We would take the temperature, examine for rash, and, if necessary, advise the mother to call the doctor. These instructive visits cost nothing and the results are seen in the healthier generation of Canadian children growing up today.

Our work as students was largely observation. As well as seeing for ourselves what was being done and helping with nursing care, we were given lectures on the keeping of records which any organization must have in order to run smoothly and efficiently, and lectures on the medical and social resources in a community such as ours. All of us, in addition to enjoying the work, at first because of the novelty and later because of the value, find that we can understand the average hospital patient so much better and give him more than just plain nursing care. We feel far better equipped to give him sound health teaching and advice as to where to turn with his own and his family's difficulties.

Well Done, Student Nurses!

In the February, 1945, issue of the *Journal* we carried a story of the campaign conducted by the student nurses in the Homoeopathic Hospital, Montreal, to bring their total of student subscriptions up to 100 per cent. During the intervening months, a number of other schools of nursing have joined the proud number of those in which all the students have become subscribers, either individually or sharing a subscription with a room-mate. The most recent group to become 100 per cent subscribed is the student body of the school of nursing of St. Paul's Hospital, Vancouver.

Why should student nurses subscribe to the national nursing *Journal*? As one of their best sources of information, both scientific and professional, they need to have ready access to *The Canadian Nurse*. But, you say, our school subscribes — it is in our library. Yes, it is there, but do you ever read it unless you have a definite assignment? We heard of one school where the *Journal* was kept on a chain lest it disappear. The incentive to read is lost. But, to have your own copy, to have it right beside your bed where you can take a glance at it before you drop off to sleep, to mull through it in your hours off—that is the way to become thoroughly acquainted with the *Journal*. Student nurse rates of eighteen months for two dollars may be applied right up to the day any student completes her training. Take advantage of this rate. Receive your own copy of *The Canadian Nurse*. Keep up to the minute with what is going on in every part of Canada. And let us know when your student body subscription list equals that of the students of St. Paul's. We will tell *them* about *your* school.

—M.E.K.

Letters to the Editor

With UNRRA in Germany

Perhaps you would like to have a little bit of information about the work here, and also about the Canadian nurses so that you can put a news item in the *Journal*. I do think we should have all the publicity possible. My official title is UNRRA Chief Nurse, British Occupational Zone. This Zone is divided into three districts and, as far as the nursing organization is concerned, in each district we have a district nursing supervisor. Under her we will soon have appointed field nursing supervisors who will have the immediate supervision of the nursing activities of anywhere from four to ten teams. Experience over here has taught us that all UNRRA nurses down to, and including, team level are really supervisors. For example, an UNRRA team has control of a group of Displaced Persons. This group may be anywhere from twelve hundred to five or more thousand. Obviously all of these people are not located in one building; they may be in many camps scattered over an area having a radius of as much as twenty miles. Therefore it is the job of the UNRRA nurse to organize and supervise nursing activities within the Centre, as we are trying to stress the public health aspect of the program. Where do we get the nurses, because we are not engaging UNRRA nurses for work any lower than team level? As I visit the teams I am told that there are so many Displaced Persons "nurses" working. Just as soon as my field supervisors are appointed they are going to get accurate details as to the qualifications of these people. I very much doubt that any considerable portion of them are really qualified nurses. We may, therefore, have to have some teaching program for nurses' aides.

Our hospital policy is not definitely defined as yet, but we are anticipating using German civilian hospitals in which the nursing is done by the German nurses. In any of those hospitals which I have visited to date the D.P. patients seem to be getting the very best of care, and the German nurses are really devoted to their task.

Each Assembly Centre has its own particular problems, and no one program can be set down. We can only work on general principles. So far we feel that the team nurse is responsible for organizing a child health program, ante-natal clinics, instructions to mothers in regard to the care of children, supervision of the children's feeding and all other aspects of the modern public health program as we know it. My feeling to date is that the best way to try to improve the health standards of Displaced Persons is through the professional members of their own group. That is why we are going to endeavour to retain as many of the qualified D.P. nurses as possible. The team nurse is also responsible for visiting the German hospitals, in which there are D.P. patients, to supervise all nursing aspects of the care given.

That, roughly, is our organizational set-up. As a matter of fact I am still waiting for one district nursing supervisor, as I am hoping very much that an American who is now stationed in the American Zone will come over. The supervisors in the other two districts are Australian and English respectively. Our ideal of mixing members of the team as to national groups was really much *too* idealistic, but I do believe that it is a good idea to have a supervisory group as representative as possible, and thus, in the meetings which we will be holding, we can really get many different views.

You will probably be interested in knowing who the Canadian nurses are who are in this Zone. In addition to myself we have Janet Brenton, Margaret Inglis, Jean Lazecko, C. L. Bartsch, and Nora Madden. These nurses came up from Italy about June 1. Norena Mackenzie is in London and is coming over here just as soon as she can get her passage. The remainder of the Canadian group arrived recently and included Germaine Bernadin, Agnes May Dunn, Frances Pearl, Lilian Rankin, Mary Wade, Jean Watt, Edna Osborne, and Janet Vanderwell, and I believe there is one other Canadian waiting in London to come — Marjorie E. Lownds. I am drawing from the Canadian group for some of the field nursing supervisors but these appointments have not yet been made.

This country is still as beautiful to me as it appeared when we first arrived. I cannot understand why Hitler permitted such destruction. In the country the people seem extremely industrious. Every inch of land is cultivated. They have at last taken in their harvest, but, because we had very heavy rain in August, much of it was spoilt. Right now the trees are beginning to change into autumn colours, and in about a month's time the hillsides should be very beautiful. I had a trip down to Frankfurt, and going through the Hartz Mountains reminded me so much of home. Frankfurt has certainly been a beautiful old city but the destruction has been terrific, and going out of the luxurious hotel into the streets, with rubble piled high and the German workers emerging from their cellars to go to work, was a bit hard to take.

About a couple of weeks ago I was lucky enough to get in a trip to Denmark as we are hoping to get some Danish nurses. Copenhagen was as lovely as I had heard that it was. There is a great shortage of transport, and you are extremely lucky if you manage to get a taxi. Incidentally all the taxis have a wood-burning apparatus on the back as there is no petrol. The bicycle is very much in vogue and the Danes ride their bicycles as though they were born on them; their motions are most rhythmic. It was grand to see the water again. Surprisingly enough the Baltic is as blue as the West Coast water! A few days before I went to Copenhagen I visited some of the camps along the shores of the Baltic in Germany. Many times I really felt I was driving through parts of Canada, especially along some of the parts of Vancouver Island.

—LYLE CREELMAN.

A Course in Midwifery

The Department of Public Health is trying to extend health services in Saskatchewan by organizing health units. There are to be about seventeen, covering the more densely populated areas, and will have hospital service, laboratory technicians, public health staff, etc. This, however, does not solve the problems in districts "far from the madding crowd" where no doctor finds it profitable to settle and where it may be too expensive for the Department to put a doctor full-time. As an experiment, nurses with public health training and a course in midwifery are to be tried in aforesaid lost and gone areas.

The Department is paying for the course for two of us at the Maternity Centre Association of New York which I will briefly describe.

The Maternity Centre Association was formed in 1918 to give nursing care to mothers who could not or would not be delivered in hospitals and among whom the mortality rate was high. While still not a large organization the M.C.A. does considerable work and is now taking in about twelve to eighteen students a year. The course is about six months and gives considerable clinic experience, pre- and post-natal care, and deliveries in the home, which the student first observes, then later performs under the watchful eye of a staff midwife. Anything abnormal which would make delivery in the home impracticable is refused if it shows up in the ante-partal period. Three doctors, who give a day each week to the clinic, make the decision as to whether or not each case is suitable for home delivery. The patient usually has two examinations by the doctor pre-natally—one immediately after registration, the other in the last month—and another examination at three months post-partum. All the other regularly spaced examinations are done by the students in the clinic supervised by staff mdiwives.

Patients have Wassermann and smear, hemoglobin and blood pressure at first examination. X-ray of chest is taken as soon as possible. If blood pressure is high, hypertension treatment is started; if blood is low in hemoglobin, iron is started and possibly liver. Diet is computed on eight-day intake and deficiencies are explained and a better diet urged. Vitamins and iron are routine in the last two months. Over a period of time it has been found that the mother is in better condition post-natally than she was on first admittance to clinic. The laboratory service is being increased to include test for Rh factor to eliminate the rare case that might be a fatality. The service is practically free. The charge of five dollars for the whole service, plus a most reasonable charge for iron and vitamins, places the service within the reach of all parents.

The class work is taken care of by Miss S. Could, instructress, and one of the doctors. We are on night call quite a lot but have no work other than study unless a call comes in. Then off go staff, senior and junior students into the tenements of Harlem, Bronx or east Manhattan. There are two

groups on duty each night, each with the same three "ratings", and a third group must be ready to come back on duty if first and second call have gone out. There is also a consultant midwife who can be called on and one of the doctors is on call also, though they are rarely called unless it is for extra sedation, and occasionally a repair is needed.

It really is a most enjoyable experience and I think the course is one of great value. The association of staff and student is markedly lacking in formality and restraint. The patient is led to think that the student who delivers is the most important of the two. Even in the clinic, the staff are only too glad to spend time and care in elucidating any problem to help the student. On week-ends, which are two days entirely on duty one week and the next week two days off, the student has a chance to talk and discuss many things with others. When she is on for the week-end, staff and students share meals and time together. The clinic is situated on East 103rd Street with tenements front, back and either side—a conglomerate of races with their joys and troubles, angers and amusements all on exhibit, as it were, in the street. I find it most interesting. The street itself is playground, nursery, park, and show for most of the inhabitants. A football game in the street itself, children's games on the sidewalks, older people gossiping from window to window and on steps. A mission two doors down and across has a revival every night with drums and cymbals, shouts and groans. People grow, live, flirt, pray, hate and love in this theatre, the street, in a show that goes on and on. I don't blame the people who spend an evening gazing and calling from the windows. I do myself! (gaze I mean of course).

In intervals we do other things — climb the Statue of Liberty, etc. We were off last week-end and wanted to go up the Hudson but it rained so we did a little more of the city instead. I hope I will not get to like the place too well and not want to go back to Saskatchewan. I don't think there is much danger. My ears just ache for silence sometimes.

—Mary P. Edwards

Editor's Note: Miss Edwards has been engaged in public health nursing in Saskatchewan for a number of years. We share her interesting account of the course in midwifery which she is taking in New York.

Nursing Sisters' Association of Canada

The annual meeting of the *Winnipeg Unit* was held in February at the home of Mrs. J. D. Moulden and took the form of a box dinner. The annual spring tea in June was convened by Emily Parker and realized the sum of $300. A bridge held in the Fort Rouge Branch of the Canadian Legion Hall netted the war fund $275. This Unit has worked mainly on behalf of the Women's Voluntary Service in Britain but local needs have not been neglected, contributions being made to the train reception committee and the Red Cross. Special mention goes to Mrs. Margaret Payne who worked faithfully on the train reception committee. Deepest sympathy is extended to her in the loss of her eldest son at Hong Kong. Many returned nursing sisters were welcomed at the Remembrance Day tea.

Since registering under the War Charities Act in 1941 the Winnipeg Unit has raised approximately $4500. Of this amount $3200 was sent to the British Women's Voluntary Service and $500 went to the Red Cross, the balance being distributed as follows: Hong Kong cigarette fund, women's naval auxiliary ditty bag fund, aid to Russia fund, Winnipeg service centre, train reception committee, British minesweepers fund, Greek relief fund, Chinese war relief fund, and homeward bound carnival.

Mrs. Hamblin and family are now in Vancouver. At a luncheon, prior to her departure, she was presented with a suitably framed petit point picture as a token of the Unit's regard. Maud Andrew, of California, formerly a nursing sister of Winnipeg, was also a guest. Mrs. McLeod, of Kamloops,

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B.C., the first president of the Unit, and now an honourary member, was a visitor in Winnipeg last summer. Her niece, N/S Hall who went overseas with No. 5 unit from Winnipeg, has returned and is taking her second year of the pre-medical course at Manitoba University. She received the A.R.R.C. and was mentioned in despatches for her overseas service. May Best, one of the Unit's original members, who has been superintendent of the American hospital in Mexico City since 1926, is now on the staff of the Alameda Hospital, Calif. A prospective new member for the Unit is Mrs. Lebetter, formerly of Yarmouth, N.S. and Ottawa.

The *Toronto Unit* held a garden party and tea in June at the home of Mrs. E. W. Mitchell. Over two hundred nursing sisters attended, including fifty recently returned from overseas. The hostess received with the president, Mrs. Gilbert Storey, and Matron Mary Shaffner of Chorley Park Military Hospital. The social convener, Mrs. Arthur Biggar, and her assistants were in charge of all arrangements. Col. Agnes Neill, Matron-in-Chief, R.C.A.M.C., was the guest speaker at the Remembrance Day dinner.

Miss C. J. Stuart's recent visit to Toronto was the reason for a get-together of No. 4 C.G.H. overseas (1915-1918) when Mrs. Driver gave a tea, as did Maud Wilkinson. Miss Stuart was the former superintendent of the Red Cross in Regina. Gladys Sharpe, formerly superintendent of nurses, Toronto Western Hospital, has left for Columbia University to complete her course for the degree of B.Sc. in Nursing, part of which was taken at Bedford College, England. Ethel Greenwood is back in civilian life and now makes her home in Woodstock, Ont. Mrs. George Hanna has retired from active duties with the Emergency Nursing Reserve of the Toronto Branch of the Red Cross. Marion Henderson will spend the winter in Florida and Marguerite Carr-Harris will be in Montreal.

NEWS NOTES

ALBERTA

EDMONTON:

University Hospital:

Over two hundred couples attended the recent annual ball of the University of Alberta Hospital Alumnae Association held in "The Barn". Student nurses and nursing students at the university were also invited. The medical theme was carried out in all decorations, the orchestra pit taking on the appearance of an operating room. Miniature nurses caps, made by the students, were given as favours.

Velma Clarke and Elna Eickmeyer headed the committee in charge of arrangements. Patronesses were Helen Peters, superintendent of nurses; Madeline McCulla, director of the University School of Nursing; and Mrs. Jack Morrison, president of the alumnae. Proceeds of the dance will be used to buy a record player for the new nurses home.

BRITISH COLUMBIA

COWICHAN CHAPTER:

A well-attended meeting of the Cowichan Chapter, R.N.A.B.C., was held recently at King's Daughters Hospital, Duncan, when both registered and graduate nurses were represented. The evening took the form of a social gathering in honour of the seven V.A.D.s of the local Red Cross, who have worked so willingly for the duration of the war. They were presented with colonial bouquets by the president. An interesting paper from *The Canadian Nurse* was read to the members. Mr. C. Giesen, who has recently returned from overseas, showed motion pictures of Peru and New Zealand. Musical selections and refreshments concluded the evening.

VANCOUVER CHAPTER:

Mrs. Grundy, president, Misses Breeton, Hawkins, McCann, Reeve, D. Jamieson, Hockins, J. E. Jamieson, and Mrs. Faulkner, members of the executive of the Vancouver Chapter, R.N.A.B.C., on behalf of the Vancouver Chapter, entertained the nursing sisters and V.A.D.s from *H.M.S. Implacable*. A drive on Sunday afternoon was followed by dinner. Members of the Council of the R.N.A.B.C. were invited to meet the nursing sisters and V.A.D.s as were the presidents of the alumnae associations of the Vancouver General Hospital (E. McCann), St. Paul's Hospital (Mrs. McKenzie), and Royal Columbian Hospital, New Westminster (Mrs. Blackburn). The place of each nursing sister and V.A.D. was identified at the table by

a maple leaf and on the leaf rested a "Thunderbird" souvenir spoon of Vancouver. These spoons were the gift of the three alumnaes and were presented to the guests of honour by Miss McCann. On Monday the presidents of the alumnaes went on board the *H.M.S. Implacable* to present spoons to N/S Colley and the V.A.D.s who remained on duty on Sunday. They were afterwards conducted over the ship. On Monday evening Mmes Grundy, Geddes, Misses McCann, Reeve, Breeton, Hawkins, and J. E. Jamieson were invited to a party on board ship and a tour completed an enjoyable visit. Lieut. Margaret Jamieson is back home, arriving in Canada on the *Ile de France*. Miss Jamieson was recently mentioned in despatches.

Vancouver General Hospital:

The following nurses are doing post-graduate work in the operating room: E. McCann, formerly instructress at the Royal Columbian Hospital and the V.G.H.; Helen Saunders, recently with the R.C.A.M.C.; A. Holmes, of the Royal Columbian Hospital; Joan Taylor, of the Hospital for Sick Children, Toronto; A. Odegarde of the Saskatoon City Hospital; E. Kenny, of St. Joseph's Hospital, Winnipeg. G. McFadyen, formerly with the R.C.A.M.C., has returned to the O.R. staff. In January Miss McFadyen will attend the University of Washington in Seattle.

NOVA SCOTIA

CANSO:

After a vacancy of several months, the position of Victorian Order district nurse at Canso has been filled by Florence Rand (Victoria General Hospital, Halifax), of Canard, who has gone to take up her duties there. Miss Rand has been on the V.O.N. Halifax staff since July, 1944. She succeeds Mrs. M. Hill who has gone to reside in Hampton, N.B. The Canso district includes Hazel Hill, Canso Tickle and Glasgow Head.

YARMOUTH & SHELBURNE COUNTIES:

Registered nurses in Yarmouth and Shelburne Counties, to the number of twenty-five, have organized and are now a branch of the Registered Nurses Association of Nova Scotia. For some time the nursing fraternity in this area has recognized the value of organizing a permanent group here to further and maintain the interests of the nursing profession and to inaugurate many suggested activities which a combination of unity and action could bring to such a group.

The following are the executive officers of the branch: president, Muriel Rice; vice-president, Mrs. Paul Trask; secretary, Margaret Boutilier; treasurer, Adelaide Munro.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

District 1

CHATHAM:

Public General Hospital:

At a recent well-attended meeting of the Chatham Public General Hospital Alumnae Association plans were made for a tea and bazaar. Mrs. M. Sheldon and Mrs. J. C. MacWilliam are in charge of the tea and Annie Head will be responsible for the bazaar. A drive is now underway for more subscriptions to the *Journal*.

Districts 2 and 3

BRANTFORD:

At the first fall meeting of the Brantford General Hospital Alumnae Association it was decided to divide the members into groups, with a captain for every group. Each group will take turns in being responsible for the program every month. Every section will also try to raise at least ten dollars for the alumnae.

At a later meeting Dr. J. R. Calder gave an interesting talk on his overseas experiences. The members also heard the Rev. G. Deane Johnston who served overseas for five years as chaplain with the army. Among other things, he told of the immediate care of the wounded on the battlefield.

District 4

HAMILTON:

A meeting of the Hamilton Chapter, District 4, R.N.A.O., was held recently at the Mount Hamilton Residence with H. Snedden presiding. Squadron Leader Dr. P. Voelker presented to the well-attended meeting, by motion pictures, the methods used in the rehabilitation of the returned soldiers in the military hospitals. A social hour followed.

Hamilton General Hospital:

At a recent meeting of the Hamilton General Hospital Alumnae Association the motion to a change in the Constitution was passed whereby the alumnae fees are raised two dollars per year. Edith Dick, acting director of the Nurse Registration Branch, told of her experiences with the Canadian Hospital unit overseas.

E. Bingeman and E. Ferguson, from the

H.G.H. staff, are taking post-graduate courses at the University of Toronto School of Nursing.

District 6

PETERBOROUGH:

Arrangements have been made with Station CHEX for a "spot" morning broadcast three times a week and once a month for fifteen minutes, in order that the public may become better acquainted with the services that the public health nursing field has to offer.

Ruth Kirkpatrick, Victorian Order nurse, has been granted leave of absence to take a course in public health nursing at the University of Toronto under a V.O.N. scholarship.

Civic Hospital:

Evelyn Lawless has been engaged as supervisor of nursing. Mae Renwick, who has completed a course in teaching and supervision at the University of Toronto, is in charge of the surgical department, north pavilion. Evelyn Reid is in charge of the surgical department, second floor, following a course in clinical supervision in surgery at the University of Toronto. Margaret McIntyre is taking a refresher course in obstetrics at the University of Toronto, while Mary Robson and Muriel Langmaid have registered for the course in clinical supervision in surgery.

St. Joseph's Hospital:

Sister M. Loretta is taking a course in advanced obstetrics at the University of Toronto.

District 8

Ottawa General Hospital:

Sisters M. Alban, St. Valere, and Madeleine of Jesus recently attended the meetings of the Canadian Hospital Council and the Catholic Hospital Association of Canada held in Hamilton.

Having completed a post-graduate course in surgery and operating room technique at St. Michael's Hospital, Toronto, Sister Andre Marie has returned to the staff as operating room supervisor. Viola Downie is now nurse-in-charge of the Red Cross Outpost in Apsley, Ont.

The following sisters from the O.G.H. are taking the nursing education and administration course at the University of Ottawa: Sisters M. Alban, Helen of Rome, Andre Marie, M. Helen, St. Martial, Raymond de Marie, M. Leonille, St. Honorine, St. Germaine, Elizabeth Marie. K. Bayley, G. Clark, F. Fournier, M. Nadon, and J. Page are taking the public health nursing course at the University of Ottawa, while M. Joyce is at the McGill School for Graduate Nurses.

QUEBEC

MONTREAL:

Montreal General Hospital:

At a recent meeting of the Montreal General Hospital Alumnae Association Dr. A. F. Fowler read a paper entitled "Presenting Newer Aspects of Diabetes". After the meeting a reception was arranged by the entertainment committee for the nursing sisters recently demobilized. A hearty welcome was also given to those recently returned from South Africa.

Recent graduates who have joined the staff are: Ruth Francis, B.A., in charge of the third floor recently opened in the Private Patients Pavilion, Western Division; E. F. Barnhill, J. E. Donaghy, M. E. Everson, A. M. Hamilton, E. D. Heatlie, E. H. Lisson, J. I. Lisson, E. C. MacDonald, J. I. Morrow, A. F. Shea, on nursing staff, Central Division. Cecil M. MacDonald is now in charge of the S.O.R., Central Division, replacing Isabel Davies who recently resigned. (See P. 897, Nov. 1945 issue of the *Journal*.)

Mabel Shannon, head nurse in gynecology, Ward O, and Elsie Denman, in charge of eye, ear, nose and throat unit, recently spent ten days in New York City on an educational tour of the hospitals in connection with their respective services. They made their first flight to and from New York.

N/S Margaret J. McCann received the M.B.E. prior to her departure from England. Miss McCann was decorated for her work under fire in Italy. A recent visitor to the school was Mrs. Jackson (Royd) Crawford who came to say farewell before leaving to join her husband in India.

Royal Victoria Hospital:

The Alumnae Association recently held its first meeting of the fall when about fifty nursing sisters were welcomed at a reception by the members of the association.

We welcome to our staff: K. Marshall (Ontario Mental Hospital and University of Toronto) as instructor, Allan Memorial Institute; E. Long (Royal Alexandra Hospital, Edmonton, and McGill School for Graduate Nurses) as instructor, Montreal Neurological Institute.

Elizabeth Hughes is now clinical instructor, women's pavilion. Marguerite McDougall and Rita Ackhurst who, until recently, were with the R.C.A.M.C., are back on the hospital staff—Miss McDougall in charge of Ross 3 and Miss Ackhurst in the main operating room. Evelyn Ward has taken a position with the Youville Hospital, Noranda.

Margaret Mowat, who served with the R.C.A.M.C., is doing post-graduate work in the neurosurgery operating room at the Presbyterian Hospital, New York. Adelaide Haggart, science instructor, spent two weeks at Yale University studying the integration of science teaching.

SASKATCHEWAN

MAPLE CREEK:

The Maple Creek Chapter recently met at the home of Mrs. Broome to say "Goodbye" to Mrs. L. (Cheeseman) Quick and "Hello" to Margaret Smith. Mrs. Quick and family are leaving for their new home at Creston, B.C. Margaret Smith is back from overseas, having spent three years with No. 8 C.G.H. Compacts were presented to the two guests and a delightful lunch was served by Mmes Broome, Hoffman, and Small.

Nellie Henley, J. MacNeill, and Alice Roberge were recently appointed to the staff of the Maple Creek General Hospital. Mrs. Ella Gunderson, night supervisor, has returned to her home at Golden Prairie, Sask.

MOOSE JAW:

Rev. Sister Bonaventure has been appointed superior of the Providence Hospital.

REGINA:

May Reid has been appointed as supervisor of the newly-opened D.V.A. wing at the Regina General Hospital. Miss Reid served with the R.C.A.M.C. for three years.

SASKATOON:

Lucy Willis was recently the first speaker of the season at the "Choice Nights" organized by the Y.W.C.A. Young Business Women's Group. Miss Willis spoke on "Health in its Broader Aspects".

City Hospital:

A preliminary class of forty-five students recently began studies at the City Hospital. Gerda Schuman, and Ruth Gilroy who was recently discharged from the R.C.A.M.C., have been appointed as clinical instructors. Mabel Barry, who has been with the V.O.N. for the past year, has been appointed as surgical supervisor. Mrs. E. (Gloeckler) Duncanson has returned to the staff as medical supervisor.

Mrs. J. Porteous, recently discharged from the R.C.A.F., and H. Bright, a member of the staff previous to enlistment in the R.C.A.M.C., are completing administration courses at the McGill School for Graduate Nurses. Mrs. C. (MacKay) Robinson, who has spent the past three and a half years in nursing service in South Africa, will leave shortly for England to join her husband.

YORKTON:

Madeline Farbacher has resigned her position on the staff of the Yorkton General Hospital to be married. A presentation was recently made to Mrs. (Langstaff) MacRae whose marriage took place recently.

WANTED

Vancouver General Hospital desires applications from Registered Nurses for **General Duty.** State in first letter date of graduation, experience, references, etc., and when services would be available.

Eight-hour day and six-day week. **Salary:** $95 per month living out, plus $19.92 Cost of Living Bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. One month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to:

Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital
Vancouver, B. C.

WANTED

Graduate Nurses are required for **General Duty** in a well-equipped 35-bed hospital. 8-hour day and 6-day week. The salary is $22 (less income tax) per week with full maintenance. Apply to:

Superintendent of Nurses, Anson General Hospital, Iroquois Falls, Ont.

WANTED

A qualified **Instructress** is required **immediately** for the **Portage la Prairie General Hospital.** Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Portage la Prairie General Hospital, Portage la Prairie, Man.

WANTED

An **Instructress of Nurses** is required for the **Kenora General Hospital.** Duties are to commence on **February 1.** Apply to:

Superintendent, Kenora General Hospital, Kenora, Ont.

WANTED

Floor Duty Nurses are required at the **Barrie Memorial Hospital.** The salary is $85.00 per month. Apply to:

Superintendent, Barrie Memorial Hospital, Ormstown, P. Q.

WANTED

Applications are invited for the following positions in a 78-bed hospital with good working and living conditions:
Qualified, experienced **Obstetrical Supervisor** for a dept. of 15 beds. Qualified **Dietitian.**

Apply, stating full particulars and qualifications, to:
Superintendent, Chipman Memorial Hospital, St. Stephen, N. B.

WANTED

General Duty Nurses are required for a 100-bed **Sanatorium.** The salary is $90 to $100 per month, with full maintenance. Four weeks' vacation with pay is allowed each year. **State in first letter date of graduation, experience,** references, etc. and when services would be available. Apply to:

Miss M. McCort, Supt. of Nurses, Niagara Peninsula Sanatorium,
St. Catharines, Ont.

WANTED

Applications are invited for the following positions in the **Hamilton General Hospital:**
Assistants for the **Delivery Floor** — day and night. Salary, $97 to $112 per month, plus complete maintenance.
General Duty nurses for **Obstetrical Dept.** Living in, $82.50 per month; living out, $100 per month.

Superintendent of Nurses, Hamilton General Hospital, Hamilton, Ont.

WANTED

Verdun Protestant Hospital desires applications from nurses for **General Staff Duty.** State in first letter, date of graduation, experience, and when services would be available. Registered Nurses are also required for the position of **Assistant Night Supervisor** and as **Charge Nurses** for wards. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Verdun, P. Q.

WANTED

A **Night Supervisor** is required for a 50-bed **Maternity Hospital.** Apply, stating qualifications, salary, etc., to:

Superintendent, Catherine Booth Mothers Hospital, 4400 Walkley Ave., Montreal 28, P. Q.

WANTED

Graduate nurses are required for **General Floor Duty** at the **Nova Scotia Sanatorium, Kentville, N. S.** The salary is $85 per month, with full maintenance. For further information apply to:

Nova Scotia Civil Service Commission, Provincial House, Halifax, N. S.

WANTED

A competent nurse is required for the position of **Operating Room Supervisor.** Apply, with references, stating experience and salary required to:

Superintendent, Prince County Hospital, Summerside, P. E. I.

WANTED

A class room **Instructress** for a 120-bed hospital. Apply stating qualifications, experience and salary expected, to:

The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

A Dietitian and a Supervisor for a Tuberculosis Annex are required immediately for the Highland View Hospital, Amherst. Apply, stating qualifications, to:

Business Manager, Highland View Hospital, Amherst, N. S.

Official Directory

THE CANADIAN NURSES ASSOCIATION

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Numerals indicate office held:* (1) *President, Provincial Nurses Association;* (2) *Chairman, Hospital and School of Nursing Section;* (3) *Chairman, Public Health Section;* (4) *Chairman, General Nursing Section.

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British Columbia: (1) Miss E. Mallory, 1066 W. 10th Ave., Vancouver; (2) Miss E. Nelson, Vancouver General Hospital; (3) Miss T. Hunter, 4238 W. 11th Ave., Vancouver; (4) Miss E. Otterbine, 1334 Nicola St., Ste. 5, Vancouver.

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Nova Scotia: (1) Miss R. MacDonald, City of Sydney Hospital; (2) Sister Catherine Gerard, Halifax Infirmary; (3) Miss M. Ross, V.O.N., Pictou; (4) Miss M. MacPhail, 29 St. Peter's Rd., Sydney.

Ontario: (1) Miss Jean I. Masten, Hospital for Sick Children, Toronto; (2) Miss B. McPhedran, Toronto Western Hospital; (3) Miss M.C. Livingston 114 Wellington St., Ottawa; (4) Miss K. Layton, 341 Sherbourne St., Toronto 2.

Prince Edward Island: (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. M. Irene, Charlottetown Hospital; (3) Miss S. Newson, Junior Red Cross, Charlottetown; (4) Miss M. Lannigan, Charlottetown Hospital.

Quebec: Miss E. Flanagan, 3801 University St., Montreal 2; (2) Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Mathews St., Montreal 25; (3) Miss A. Girard, l'Ecole d'infirmières hygiénistes, University of Montreal, 2900 Mt. Royal Blvd., Montreal 26; (4) Miss E. Killins, 1230 Bishop St., Montreal 25.

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New Brunswick Ass'n of Registered Nurses: Miss Alma F. Law, 29 Wellington Row, Saint John.

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Registered Nurses Ass'n of Ontario: Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.

Prince Edward Island Registered Nurses Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlottetown.

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Saskatchewan Registered Nurses Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

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Ponoka District, No. 2, A.A.R.N.

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Lethbridge District, No. 8, A.A.R.N.

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BRITISH COLUMBIA

Registered Nurses Association of British Columbia

Pres., Miss Evelyn Mallory, 1086 W. 10th Ave., Vancouver; First Vice-Pres., Miss E. Palliser; Sec. Vice-Pres., Miss E. Clark; Hon. Sec., Miss E. Paulson; Hon. Treas., Mrs. E. Pringle; Past Pres., Miss G. Fairley; *Section Chairmen*: *General Nursing*, Miss E. Otterbine, 1384 Nicola St., Ste. 5, Vancouver; *Hospital & School of Nursing*, Miss E. Nelson, Vancouver General Hospital; *Public Health*, Miss T. Hunter, 4238 W. 11th Ave., Vancouver; *District Councillors*: *Greater Vancouver*, Mrs. L. Grundy, Misses E. Copeland, K. Lee; *Vancouver Island*, Misses M. Baird, M. Rondeau; *Kamloops-Okanagan*, Miss O. Garrood; *West Kootenay*, Miss M. Heeney; *East Kootenay*, To be appointed; Executive Secretary & Registrar, Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.

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Vancouver Island District

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East Kootenay District

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West Kootenay District

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Manitoba Association of Registered Nurses

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PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

Pres., Miss Dorothy Cox, 101 Weymouth St., Charlottetown; Vice-Pres., Miss Mildred Thompson, P. E. I. Hospital, Charlottetown; Sec., Miss Helen Arsenault, Provincial Sanatorium, Charlottetown; Treas. & Registrar, Sr. M. Magdalen, Charlottetown Hospital; *Section Chairmen: Public Health*, Miss Sophie Newson, Junior Red Cross, Charlottetown; *Hospital & School of Nursing*, Sr. M. Irene, Charlottetown Hospital; *General Nursing*, Miss Mary Lannigan, Charlottetown Hospital.

QUEBEC

Registered Nurses Association of the Province of Quebec (Incorporated 1920)

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SASKATCHEWAN

Saskatchewan Registered Nurses Association (Incorporated 1917)

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Regina Chapter, District 7, Saskatchewan Registered Nurses Association

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Alumnae Associations

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A.A., Calgary General Hospital, Calgary

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A.A., Edmonton General Hospital, Edmonton

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